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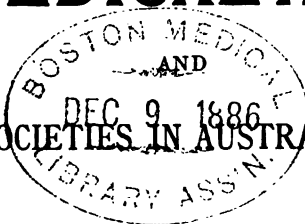
BEING THE

OFFICIAL ORGAN OF THE COMBINED AUSTRALASIAN BRANCHES

OF THE

BRITISH MEDICAL ASSOCIATION,

OTHER MEDICAL SOCIETIES IN AUSTRALIA AND NEW ZEALAND.



VOL. IV.

Edited by The Hon. JOHN MILDRED CREED, M.L.C., L.R.C.P., M.R.C.S.E., &c.

FROM OCTOBER, 1884, TO SEPTEMBER, 1885.

Sydney:

L. BRUCK, MEDICAL PUBLISHER.

1885.

RECEIVED,

NOV 10 1886.

7/17/86.

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AUSTRALASIAN MEDICAL GAZETTE.

CLINICAL LECTURE

ON ANEURISM OF THE INNOMINATE ARTERY.

DELIVERED AT THE MELBOURNE HOSPITAL

BY THE HONORABLE JAMES GEORGE BEANEY,
M.P., M.D., F.R.C.S.E., L.K.Q.C.P.I.,
M.R.I.A., HON. SURGEON TO THE HOSPITAL.

GENTLEMEN:—I have chosen as a text for this morning's lecture two cases of aneurism of the innominate artery, which you have had an opportunity of seeing treated by me in the surgical wards. I am also pleased to congratulate you on the very great attention you have given to them during their sojourn in the Hospital. The patients are now before you, and I regard their presence here to-day as a happy augury of many and greater triumphs in the domain of practical surgery. The operating surgeon incurs a grave responsibility when he essays the performance of an operation in which death may speedily follow the first plunge of the knife, although the highest degree of skill and the greatest experience be brought to its point. And yet what a proud satisfaction awaits him when he has, by a bold and skilfully designed operation, been the means of arresting or removing a disease that had already opened the grave for its victim. We will now glance at the notes taken of the first case.

CASE I.—Aneurism of the innominate artery; trachea pushed to left side; great difficulty in breathing; hæmoptysis; consecutive deligation of carotid and subclavian arteries. Recovery.

Robert S—, aged thirty-eight, by occupation a wood-turner, was admitted into Ward XVIII., September 10th, 1883, suffering from a pulsating tumour at the root of the neck.

HISTORY.—Patient states that about six months ago he suffered from a severe pain in the right shoulder, extending upwards behind the ear, accompanied with a sense of giddiness. He says he felt as if he had a stiff neck, and was considerably depressed in spirits. About six weeks subsequently he had a troublesome cough, which he describes as being "like the bark of a dog," accompanied by a slight expectoration of a viscid character, streaked with blood; and his breathing was somewhat embarrassed, becoming more so on lying down, his sleep being disturbed thereby, and unrefreshing.

Shortly after he noticed a small swelling on the right side of the neck, which gradually increased. The parts round about the swelling were also considerably enlarged, and very tender

to the touch. He continued to work at his trade, but after finishing his day's work the pain would come on, and becoming much worse at night his sleep was disturbed thereby. He says he has always been a temperate man. His brothers and sisters are all alive and well. There is no family history of heart disease, aneurism, syphilis or rheumatism; but when about twenty years of age he contracted a Hunterian chancre, followed by syphilitic fever, roseolar eruption, and sore throat. For these symptoms he was treated at a London Hospital, and was profusely salivated. He has never undergone any athletic training, nor has he essayed any great feats of physical strength.

On Admission, he is fairly nourished, with a well-formed chest. He is pale and despondent. His urinary secretion is sufficient, and free from albumen. At the right sterno-clavicular joint there is a well-marked ovoidal pulsating swelling, which extends about two inches above the inner third of the clavicle. The pulsation area extends downwards as far as the second rib and across the sternum. There is a dull aching pain in the tumour. Tactile examination causes considerable pain and dyspnoea. On applying the stethoscope a loud bellows sound is heard over the area of pulsation. Pressure applied to the carotid and subclavian arteries simultaneously cause the pulsation and bruit in the tumour to be considerably diminished. The superficial veins are by no means prominent, but there is a well-marked zone of capillaries across the lower part of the chest. The arynx is considerably displaced to the left side of the neck. He suffers from dysphagia; has a short, troublesome cough, accompanied with a bloody viscid and tenacious expectoration. Auscultation and percussion fail to discover any lesion of the pulmonary organs. The heart's impulse is weak, but there is an absence of systolic or diastolic murmurs; the apex beat appears somewhat displaced downwards and inwards to the seventh rib, and more than an inch internal to the nipple line. The right radial pulse is 88, and distinctly weaker than the left. The pupillary area of both eyes is equal. There is a sinus in the left groin, and the spermatic cord is thickened, and slightly tender.

Two days after his admission a consultation was held by the Hospital staff, and it was considered advisable, on account of the urgency of the symptoms, to give the patient a chance for his life by first applying a ligature to the carotid artery, and subsequently, if deemed expedient, to deligate the subclavian in the third part of its course. At about seven o'clock in the evening he complained of considerable pain about the neck

and chest, his temperature being 99°. He was ordered a draught composed of Battley's solution of opium, with chloral and cinnamon water. During the night he slept fairly well, and his breathing was somewhat easier. On the following day there was considerable amelioration of the symptoms which had caused him so much distress, and this improvement continued until the morning of the 16th, when he complained of shortness of breath, with intolerable pain about the tumour. During the afternoon he had a severe attack of coughing, accompanied with frothy and bloody expectoration, and his respiratory movements were somewhat jerky and laboured. A belladonna plaster was applied to the tumour, and a mixture was ordered to be administered every three hours, composed of hydrocyanic acid, chloroform, compound tincture of camphor, with syrup of tolu and distilled water. On the morning of the 17th his cough was much better, and although the dyspnoea was troublesome, the expectoration was free from blood; his pulse was 96, soft, and he had slept fairly well during the night. On the 19th he is reported as much better; his breathing was more tranquil, and he had no head symptoms. There was no blood in the sputum. Urinary secretion was examined, and found normal. The pupils were equal.

CAROTID OPERATION.—On the 21st it was decided to operate, although it was feared that the formidable nature of the undertaking was more than the patient in his already exhausted condition could bear. He was brought into the operating theatre at three o'clock p.m., and was placed under the influence of chloroform. When the stage of complete insensibility was reached I made an incision along the anterior border of the sterno-mastoid, in a line with the vessel; the deep fascia was soon reached, and divided. The sterno-mastoid and omo-hyoid muscles were held apart by retractors, the sheath opened, and a ligature of prepared kangaroo tendon was passed around the artery, which was pulsating very feebly at the time; the wound was irrigated with a 5 per cent. solution of carbolic acid, its edges approximated with silver wire, and a drainage tube inserted. I may add that immediately on tightening the ligature the right pupil became much contracted, and the veins of the forehead very turgid. The patient was then removed to a special ward, well wrapped in blankets, and hot-water bags applied to his feet. In a short time he recovered from the effects of the anæsthetic, and complained of dyspnoea, owing to the presence of a quantity of mucus in the trachea. His pulse was 120, and his temperature was 100·3 F. Ordered a draught composed of bromide of soda and chloral.

22nd.—Heart's action a good deal disturbed, and right pupil contracted; both, however, responsive to light. Pulse quick; the left stronger than the right. Not much discharge from the wound, which was dressed antiseptically. He slept fairly well, and could swallow with less difficulty; his breathing was easier, and cough less troublesome, but complained a good deal of headache. Pulse, 120; temperature, 102·4 F. He was allowed plenty of iced milk. On the 23rd the patient was much easier in every way, and his head felt more comfortable. The pupils were still unequal, and there was no pulsation in the temporal or facial arteries. The right side of the face was paler than the left. The wound looked well, and was dressed with terebinte. The turgidity of the veins of the forehead noticed after the operation had disappeared. As he was somewhat restless he was ordered a draught of bromide of soda, with belladonna and mint-water, to be taken at bedtime.

On the 25th he is reported as having no headache, and that he slept for five hours after the draught; that some consolidation appears to have taken place in the aneurism on its inner side, and the pulsation is much diminished. The bowels being constipated, a saline aperient was ordered.

On the 27th there was no pain in the head, and his breathing had become more normal. The right radial pulse was much weaker than the left; there was a slight cough, with very little expectoration. The colour and temperature of both cheeks were nearly equal. There was pulsation in the right temporal and right external carotid arteries. Pulse, 110; temperature, 100° F. Appearance of the aneurism much the same.

On the 30th his temperature was 99°; pulse, 100, soft; tongue moist; bowels open. He has been sleeping well, although he complains of dizziness in the head, becoming worse towards night. Aneurism pulsating more feebly, but the area of pulsation is not much diminished; measurement of tumour gives 1½ inches from above downwards, and 2½ inches from side to side.

October 2nd.—Patient complained of a sensation as of "something moving in the head," and feeling drowsy. There was no pulsation in the right temporal artery. His pulse was 110; respirations, 28; temperature, 99·3 F. No bruit could be heard over the aneurism.

On the 5th his head felt better, and his tongue was clean; pulse still quick, and the temperature was normal. The pupil of the right eye still contracted, and his vision is somewhat impaired.

On the 9th the report tells us that his breathing was a little short, that he slept a good deal during the day, and that the area of pulsation did not appear to diminish. The wound was nearly healed.

On the 18th we find that the pulsation in the tumour is, if anything, greater than it was a week ago. The tumour measures 2 inches vertically by 8 inches laterally. Complains of dysphagia, and has a slight dry cough. There is slight pulsation in the temporal artery; bowels constipated, for which he was ordered a carminative aperient.

On the 17th the patient complained again of pressure on the windpipe, with a troublesome cough; his tongue was clean and moist, and his bowels were acting.

On the 19th it became evident that the deligation of the carotid alone would inevitably fail in bringing the case to a successful issue. I therefore decided to apply a ligature to the subclavian in the third part of its course.

SUBCLAVIAN OPERATION.—The patient was placed under the influence of chloroform, with his face turned to the opposite side. I then drew the skin downwards nearly an inch, and made a transverse incision above and parallel to the posterior border of the clavicle, extending from the external border of the sterno-mastoid to the trapezius. The deeper tissues were torn through, and a large vein exposed, to which I applied a double catgut ligature, and divided it between. With my index finger passed into the depths of the wound, I could feel the artery beating very feebly just behind the scalene tubercle of the first rib. The sheath was opened, and an aneurism needle passed from above downwards; the latter was armed with prepared kangaroo tendon, and withdrawn; the artery was then tightly ligatured. It was noticed that before tying the vessel very little pulsation of the artery was to be seen or felt; in fact, it was a mere thrill. This would account for the disappearance of the pulse at the wrist immediately after he was rendered insensible from the anæsthetic. The wound was irrigated with a solution of chloride of zinc, well dried, and the edges brought together with silver wire and horse-hair sutures; a small drainage tube was inserted, and the wound dressed antiseptically. The arm was then enveloped in cotton wool, over which was applied a flannel bandage. Hot-water bags were applied to his feet and loins, and the arm was a little elevated. A quarter of a grain of morphia, with a sixtieth of a grain of atropine, was injected before leaving the operating-room. At ten o'clock p.m. he had slept a little, but complained of numbness in the right arm. His pulse was 148, his respirations were 40, and he had vomited a little. On changing his position a little blood-stained discharge came from beneath the dressings.

On the 20th his pulse was 128, and his respirations 28; temperature, 102° F. He had

vomited frequently, and was suffering from headache. He appeared much depressed. He was ordered an effervescent mixture, with hydrocyanic acid and bismuth, every four hours. On the 21st he had a feeling of nausea, but had not vomited for some hours. His pulse was 144, and his respirations 28; temperature the same as yesterday. At ten o'clock p.m. he complained of numbness in the wrist and elbow, with slight dysphagia; pulse 116, respirations 20. On the 22nd the right hand was warm, and he complained of paroxysmal pains in the right elbow and wrist. There was no change in the tumour. Complained of pain in the upper part of the epigastrium and in the middle of the sternum; appeared very low spirited. He was ordered a hypodermic injection. On the 23rd two sutures removed from the wound, which was syringed and dressed; the pupil not so much contracted; complained of pain in the left knee. On the 24th the pain in the knee had subsided; had pain in the head and lower part of the sternum; the lung sounds are clear; pulse 148, soft and compressible. The hypodermic to be repeated. 25th, there was a free discharge of healthy pus from the wound, and some swelling about the chest below the incision; this extends down along the inner side of the arm. Several sutures removed. He was ordered a mixture of chlorate of potassa, with a bitter infusion, every three hours. His pulse was 180; temperature, 104° F.; was very thirsty. Morphia injection repeated. On the 27th he complained of a burning pain in the fingers, with considerable œdema of the arm. Pulse, 112, full; temperature, 103°; discharge from the wound healthy; the swelling to be painted with tincture of iodine. There was considerable pulsation in the tumour. He was then ordered two minim doses of tincture of veratrum viride every hour. On the 29th the veratrum viride was increased to two minims every hour, as the pulse was 130, and bounding. On the 31st he complained of a peculiar feeling in the front of the head, as if something were "crawling on the floor of the brain." Pulse, 98; more cheerful, and wished to be supplied with more food. Had no cough; had considerable pain and tenderness in the axilla, towards the arm. He was ordered linseed meal poultices, in which carbolic oil was mixed, to be constantly applied. Subclavian wound nearly healed. On the 4th of November he is reported as not having slept, on account of throbbing pain in the upper part of the arm. Pulse, 100; temperature, 100·4° F. Great thirst. An incision was made high up, near the axilla, and about three ounces of pus was evacuated; it apparently came from beneath the pectorals, as well as from the arm. On the 7th the purulent

discharge from the arm had ceased. The temperature was 99°. There was no bruit heard over the tumour. The swelling of the arm had subsided. From the 7th until the 17th he seemed to progress favourably, but the veratrum had to be discontinued, on account of the nausea and depression it induced.

From the 19th of November until the 14th of December the veratrum was pushed in gradually increasing doses until he was taking 15 minims every three hours; and during that time the æther spray had been applied once a day, and finally every alternate day, to the tumour. As the veratrum was depressing him to such an extent as to keep him almost in a state of perpetual syncope, it was stopped entirely, when he was ordered large doses of tincture or perchloride of iron with sulphate of magnesia, and the æther spray to be continued. On the 20th of December the patient was evidently improving rapidly, although there was some difference in the size of the pupils. He slept well; complained of being kept short of food; he was in good spirits; the tumour was much reduced in size; there was very slight pulsation, and the sac seemed greatly thickened from laminated deposit. In January he was allowed to leave the Hospital for a change of air, and about two months subsequently to his leaving he called upon me, and appeared to be in good health—in fact, he had returned to his work. At the site of the original swelling there was a hard, small lump, about the size of a walnut. It had no bruit, but there was a small, faintly pulsating area. The heart's sounds were normal, and the lungs were healthy.

I have now given you the history and progress of this eventful case, and I am desirous of calling your attention to some of the clinical features in connection therewith. I shall, therefore, deal with (1st) the diagnosis of the case; (2nd) the causation of the aneurism; (3rd) its treatment by distal ligature; (4th) the symptomatic phenomena observed during its treatment and progress; (5th) the probable nature of the agents at work in retarding recovery; followed by restoration to health.

When this man was admitted into the Hospital he was in a very exhausted state. He was suffering from a severe paroxysmal cough, accompanied with bloody expectoration; his breathing was hurried and laborious, and there was also present considerable difficulty in swallowing; in fact, the pressure seemed so great upon the nerves of respiration that an attack of spasmodic laryngeal obstruction appeared likely to occur at any moment, and death might rapidly follow unless tracheotomy could be safely performed; and in a case like the present such an

operation would be attended with some difficulty, owing to the displacement of the trachea to the left side, and the congested state of the veins of the neck.

And now we come to the question of the diagnosis. Was this a case of innominate aneurism? I think the physical signs justify us in replying in the affirmative, although some medical visitors thought it might be an aneurism of the aorta. Now, I think the diagnosis of the case from an aortic aneurism was rendered sufficiently easy. There was a well-marked pulsating tumour situated at the right sternoclavicular joint, immediately above the inner third of the clavicle; the trachea was displaced, and pushed considerably over to the left side; the right subclavian artery was pressed upon, as evidenced by the feeble pulsation at the wrist; and it was found that pressure on the carotid and subclavian artery considerably diminished the aneurismal beat and bellows murmur. Finally, the severe pain was limited to the right side of the neck; and these symptoms, together with the paroxysmal dyspnoea and cough, with dysphagia, pointed to pressure of the tumour on the recurrent and sympathetic nerves.

We will now briefly consider what the probable causes of this aneurism were. As an aneurismal dilatation cannot take place in a healthy blood-vessel, to what may be attributed the degenerative changes in the arterial walls which culminated in the development of this aneurism? The patient tells us he is thirty-eight years old, and of temperate habits; that he has never suffered from rheumatism, gout, or alcoholism; but there is a distinct syphilitic history in his case, for he tells us that many years ago, when in England, he contracted a hard chancre, and this was followed by syphilitic fever, roseolar eruption, and sore throat, for which he was profusely salivated at a London hospital. For some time after this he was wanting in vigour, and he lost colour; but, although never robust, he was able to fulfil the duties of his calling, that of a wood-turner. I think, therefore, we may assume that the lesion in this case was due to the elasticity of the vessel being impaired by structural changes, and that these changes were undoubtedly due to a syphilitic cachexia. You will remember the case of the Kanaka who was admitted into Ward I, suffering from ruptured popliteal aneurism, and whose leg I amputated at the middle third of the thigh. When he came into the Hospital he was covered with secondary syphilitic eruptions on the skin.*

* Mr. Berkeley Hill (*Syphilis and Local Contagious Disorders*, p. 200) observes:—"There is good reason to believe that syphilis is a predisposing cause of atheroma, and doubtless atheroma is often the starting

I remember, when serving with my regiment in the Mediterranean, invaliding a soldier to England who was suffering from a popliteal aneurism, who had previously suffered from Hunterian chancre, ulceration of the tongue and throat, followed by alopecia. Dr. Lewer, of the Army Medical Department, in 1862, reported a case of aneurism of the thoracic aorta, resulting from syphilis; and Professor Aitken, of the Army Medical School, in his *Science and Practice of Medicine*, makes the following remarks:—

"With regard to the influence of syphilis, I may here observe that I dissected, during four years (at Fort Pitt and Netley hospitals for invalids), twenty-six bodies of soldiers, in each of which a distinct history of syphilis was present, associated with unmistakable syphilitic lesions; and of these twenty-six cases *seventeen* had the coats of the thoracic aorta impaired by characteristic changes—changes which are uncommon at an early period of life, and which I have every reason to believe were due to syphilis—a *syphilitic arteritis*. The changes are obvious, from cicatricial-like loss of substance of the inner coats, small local dilatations of the artery, and in several cases aneurismal expansions, one as large as an orange, which proved fatal."

I think, therefore, Gentlemen, we may rightly regard the case under consideration as an aneurism of the innominate artery, due to syphilis as its predisposing cause.

The eminently satisfactory results obtained in the treatment of this case by distal ligation of the

point for subsequent aneurism. Welch collected from the records of Netley fifty-three cases of aortic pouching or sacculation, in thirty-four of which the dilatation had developed into aneurism. In 66 per cent. of the fifty-three cases the patients had been undoubtedly infected with syphilis. It must be borne in mind that all these examples were taken from soldiers, a class particularly liable to vascular disease; but examination of their cases did not show any other factor than syphilis to have prevailed. Welch goes further than this: his researches show that the nodular circumscribed form of atheroma is the one most frequently developed in the larger vessels of syphilitic patients, while it is the exceptional form in the rheumatic or chronic alcoholic diathesis. Cases are recorded where aneurisms of the larger vessels have been discovered by *post-mortem* examination in syphilitic persons; but the connection between such aneurism and the syphilitic condition of the patients has never been quite successfully traced. Wilks and Moxon call attention to this want of completeness in the chain of evidence, and point out that in the various *post-mortem* records of women who have had syphilitic disease during life, aneurism is rarely noted. At the discussion which followed the exhibition of a specimen of multiple aneurisms of the aorta, by Vallin, at the Société Médicale des Hôpitaux in 1879, Fournier expressed his belief that syphilis may be a predisposing cause of aneurism by its tendency to excite atheromatous degeneration of the arteries, and said that he had observed an aneurism of the aorta in a patient who had syphilitic periostitis."

carotid and subclavian arteries must inevitably stamp it as a justifiable operation in similar cases, and I fully concur in the opinion expressed by Mr. Holmes, of St. George's Hospital, that the carotid artery should in all cases be tied first.*

In the treatment of an aneurism by distal ligation the surgeon endeavours to fill the sac with concentric layers of fibrinised coagula, through which the blood may flow without the risk of rupture of the sac; and the success of the operation depends, not so much upon retarding the blood-current through the tumour, as by the extension of coagulation from the tied artery into the sac of the aneurism. Now, in the case under consideration it was observed that the process of consolidation of the tumour by fibrinisation of the contents of the sac was retarded in a very marked degree. Was this due to a morbid condition of the blood plasma? I think it was, because his progress was anything but satisfactory while his diet was spare, and he was kept under the influence of iodide of potassium, veratrum viride, and aconite; but so soon as this treatment was discontinued, and replaced by a more liberal diet and a mixture containing the tincture of the perchloride of iron, while he was carried into the garden every day when the weather permitted, his improvement was rapid and pronounced. Did the freezing process by means of the æther spray contribute in any way to the success of the treatment? I think it did, although it is a question one cannot answer in the affirmative.

(To be concluded in our next issue.)

*Mr. T. Holmes (*Surgery: Its Principles and Practice*, p. 536) observes:—"As I have myself tied the subclavian (third part) and the carotid simultaneously in a case of innominate aneurism, I need hardly say that I think the distal operation justifiable in appropriate cases of this affection. But I must say that the study of my own case and of the published records of the others has led me to the decided conviction that the benefit which has been obtained in some of them has been due usually to the ligation of the carotid by which the carotid or tracheal portion of the sac has been obliterated; and I should be disposed in any future cases to commence with the less severe measure of tying the right carotid. It must be remembered that the large branches from the first part of the subclavian must carry on the collateral circulation after the third part of that artery has been tied; and for this purpose the circulation must go on through the sac into the first part of the subclavian artery, and probably with increased force, after the operation, so that the entire obliteration of the sac by the distal ligation seems impossible unless the first part of the subclavian could be secured inside its large branches, which, up to the present time, has been found incompatible with the patient's recovery, even without the complication of ligation of the right carotid. Still Mr. Fearn's case, where a practical cure certainly resulted (a channel about the size of the original artery being maintained through the clot which filled the aneurism), is an encouragement for tying the two arteries either simultaneously or, perhaps better, with an interval, as in that case."

ORIGINAL ARTICLE.

RETROVERSION OF THE GRAVID UTERUS, ACCOMPANIED WITH RETENTION OF URINE.

By JAS. D. DUNLOP, M.B., L.R.C.S., EDIN.,
SEN. HOUSE SURGEON, ADELAIDE HOSPITAL.

Case I. H.C., aged 30, a multipara, was admitted on October 26, complaining of a swelling of the abdomen and inability to pass water. Had not menstruated for 4 months. Was previously regular.

A fluctuating tumour was found distending the abdomen and reaching above the umbilicus.

Per vaginam. The fundus uteri was found occupying the hollow of the sacrum. It was enlarged and evidently pregnant at about the 4th month. The cervix was found pulled up behind the pubis and the os patulous.

The urine was drawn off, and next morning the cervix was found to be in natural position and the os still patulous. Patient was able to void urine by herself.

On the 29th she aborted, and left the hospital about a week afterwards in her usual good state of health.

Case II. S.M., 27, was admitted to hospital November 12th, complaining of pain in abdomen and constant dribbling of urine.

Had had pain in lower part of abdomen about a month. The dribbling of urine began three weeks before admission.

She had been washing at the beginning of the period mentioned, i.e., four weeks, and felt the pain gradually come on after lifting a heavy tub. An hour or two after, the pain became severe and continued till time of seeking advice. The night on which she strained herself she could not make water, and next morning noticed a swelling of her abdomen which got gradually larger and harder. Continuous dribbling of urine did not begin for a week after; patient being able up till then to urinate with difficulty at long intervals.

She had not menstruated for 11 weeks, but was previously regular. Had three children, the eldest 6 years, and the youngest, 1 year and 8 months old. Menstruation reappeared a year after the birth of her last child.

On palpating the abdomen on admission, a large fluctuating tumour was felt reaching midway between the umbilicus and ensiform cartilage. This was considered to be the distended bladder, and a catheter was passed. The urethral orifice was dragged far up. About 70oz. of urine were drawn off. Next morning 60oz. were drawn off, and two hours after a flattened fluctuating tumour could still be felt reaching almost to the umbilicus.

The catheter was again introduced, and another 60oz. of urine obtained. It was pale in color, specific gravity 1005, slightly acid, and contained a faint cloud of albumen. The flattened tumour has now disappeared.

On making an examination per vaginam, the following conditions were found. The vagina was roomy and moist. The posterior wall was lax and to some extent prolapsed or pushed down in front of the fundus uteri. The anterior wall was tense. The finger on passing into the vagina impinged on a tumour, elastic and varying in tension, and about the size of a large citron. It bulged forward the posterior wall of the vagina, and was about 1½ in. above the fourchette and resting on the perineal body. About 1 in. further up was felt a soft, lax tumour in front of that just mentioned. In this two bodies about the size of unshelled almonds could be felt, exquisitely tender and making the patient feel faint when touched. This last tumour was considered to be the displaced Pouch of Douglas, containing the ovaries. The cervix could just be reached high above the pubis, and at an angle with the body of the uterus. The os was moderately patulous and transverse.

The patient's temperature the evening after admission was 103°. A systolic cardiac bruit was heard, loudest a little to left of pulmonary area, but also audible at apex. During the next day somewhat over nine pints of urine were drawn off, and this was about her average daily quantity for some days. The temperature was still above normal (101°).

Two days after admission an attempt was made to replace the uterus by placing the patient in the genu-pectoral position. This was partially successful, and a ring pessary was introduced to retain the advantage gained. Urine: Specific gravity 1005. Slight quantity of albumen.

Next day (14th November). Pretty easy. Has some "forcing" pains.

19th. Daily quantity of urine about 9 pints, but patient states that she has long been in the habit of passing large quantities of urine, having to get up several times during the night for that purpose. Uterus has fallen back. Pessary removed.

22nd. The patient has passed a little urine normally to-day, and feels much easier. Constant catheterisation.

26th. Still retention of urine, necessitating the continued use of the catheter. The uterus is higher up and more freely movable. Daily quantity of urine about 6 pints.

December 3rd. Patient has been up, and uterus is lower again. There is also a whitish discharge from vagina. Confined more rigidly to bed.

6th. Has been able to pass urine normally for two days. Uterus is now high and in normal position.

14th. Discharged well.

Remarks. This case is interesting as being complicated with marked polyuria. It is also noteworthy that after all the ordinary methods of replacing and retaining the uterus in normal position had failed, it eventually and of its own accord righted itself, the only treatment being complete rest, free administration of opium (which was well borne in spite of the albumenuria), and the constant and systematic emptying of the bladder.

In painful contrast to the above case is :—

Case III. F.A., a primipara, aged 31, was brought in a cab to the hospital by two men (one of them her husband), at about half-past ten on the Christmas morning of 1883.

On admission she was comatose. The breathing was slow and laboured; the pulse almost imperceptible; the eyes half closed, irresponsive to light, and very feebly so to touch. The lips and teeth were thickly covered with sordes, and she had passed a motion, consisting chiefly of blood, into her clothes.

At an inquest which was subsequently held on my refusing to give a certificate of cause of death, it was elicited that the woman had been ill for a fortnight, having hurt herself at the beginning of that time lifting a heavy weight. Since then she had suffered from obstinate constipation, pain in the abdomen, and constant dribbling of urine.

A man styling himself "Dr." but who had no qualification, although practising under the auspices of a qualified practitioner, was called in. He failed to diagnose the case, and prescribed the great sheet-anchor of such persons—a mixture of rhubarb and soda. After a few days he offended his patient by his somewhat gross and characteristic familiarity, and was dismissed, a legally qualified medical gentleman being called in. The patient, acting on the information imparted by the unqualified practitioner (who during his attendance told her that she was at her seventh month, instead of the fourth, as she imagined) assured the doctor now called that she was at her seventh month, and even engaged him to attend her at her impending confinement in two months time. Thus led off the scent, the qualified gentleman unfortunately came no nearer a true diagnosis of the case than the quack afore-mentioned, except in so far as he judged the case to be one of uræmia. After attending the case for three days, he sent her to the hospital, where she arrived moribund and died a few hours after admission.

On being placed in bed the bladder was found distended and reaching above the umbilicus. The nurse of her own accord passed a gum-elastic

catheter and drew off over 80oz. of bloody urine, leaving the abdomen flaccid.

On making a per vaginam examination I found the cervix pulled high above the pubis, and the os not to be reached by the finger. The anterior vaginal wall was very tense, the posterior slack and somewhat prolapsed. The body of the uterus (which was evidently pregnant at about the 4th month) was retroverted, filling the hollow of the sacrum. It was fixed and immovable, and could be plainly felt contracting at intervals. The temperature in axilla was 97° F., the general condition of the patient as before described.

At 6 p.m., the nurse on drawing the patient's urine, noticed blood issuing from the vagina. Having informed me of this, I introduced my fingers and extracted a foetus of about the 4th month from the vaginal passage. The placenta was somewhat adherent, but was removed entire. There was very little hæmorrhage, but the patient's general condition was much worse, the hands and feet cold, breath very slow, shallow, and laboured, no pulse to be felt at wrist.

I saw her again at 7.45 p.m., when she was almost in the act of dying. The nurse had drawn off a pint of bloody urine, and the patient, who throughout had been entirely unconscious and incapable of movement, or of taking nourishment, died at 8.20 p.m.

The following notes of the conditions observed at a subsequent post-mortem examination are extracted from the hospital records :—

Post-mortem made forty-eight hours after death by instructions from Coroner.

Body fairly well nourished, abdominal walls retracted.

On opening the abdomen the bladder was found much enlarged, and lying flaccid upon the intestines, reaching above the umbilicus. It was considerably thickened. On removing it and cutting it open, it was found to contain a quantity (about 10oz.) of clots and dark fluid-blood mixed with a little urine. The mucous membrane was much congested in several places, and there was a sloughing, ulcerated patch, about the size of a halfpenny near the neck of the bladder, at a point corresponding to where the cervix uteri had pressed and from which the bulk of the hæmorrhage had probably taken place.

The uterus was found enlarged and retroverted, almost entirely filling the outlet of the pelvis. At its right upper angle was a subperitoneal fibroid tumour about the size of a mandarin orange. The lower lumbar vertebræ were unusually curved forwards and the promontory of the sacrum very prominent. The os uteri was occupied by a small fibrinous clot, and the cavity of the body was empty except for a few shreds of placenta, which

were adherent to its walls. The ureters were a little dilated, but otherwise healthy. The kidneys and other viscera—abdominal and thoracic—were apparently normal.

The brain was not examined.

Remarks :—This case is interesting as illustrating one of the dangers of retroversion of the gravid uterus and consequent retention of urine, viz., the ulceration of the wall of the bladder from pressure of the cervix uteri and extensive hæmorrhage. The fact of abortion occurring, even in the moribund condition of the patient, so soon after the withdrawal of the urine, shows how readily amenable to judicious treatment the case might have been in the first instance. It also serves as a painful illustration of the danger persons run from unqualified practitioners being allowed indiscriminate license to practice. The unqualified man in this case not only having entirely mistaken the nature of the malady, but having also misled the patient by giving her wrong information as to the state of her pregnancy, and thus causing her to mislead the regular practitioner in turn.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards :—

NEW ZEALAND.

Fisher, William Allen, L.R.C.P. et R.E.S., Edin., 1888.
March, Wilfred, L.S.A., Lond., 1881.
Clarke, Alexander, L.R.C.P. et R.C.S., Edin., 1864.
Satchell, Charles George, M.R.C.S.E., L.S.A., Lond.

QUEENSLAND.

Hodson, Francis Octavius, L. et L. Mid., K.Q.C.P., Irel., 1883.
McMurray, Wahab, M.D. et Ch.M., Qu. Univ., Irel., 1881.
Rowlett, William Edwin.
Hill, James.
Nicoll, Alexander.

SOUTH AUSTRALIA.

Morier, Charles George Drummond, L.R.C.S., Irel., 1883; L. et L. Mid., K.Q.C.P., Irel., 1883.
Wigg, Henry Higham, M.R.C.S., Eng., 1883; L.R.C.P., Lond., 1883.

VICTORIA.

Branson, George Attenborough, M.R.C.S., Eng., 1881; L.R.C.P., Edin., 1881; L.M., Edin., 1881.
Taaffe, John Ferdinand Hugh, L.S.A., Lond., 1883.
Catts, William Henry, M.B. et Ch. B., Melb., 1883.
Usher, John Edward, L.S.A., Lond., 1880; L.R.C.P., Lond., 1881.
Fenwick, Henry Marshall, M.R.C.S., Eng., 1883; M.B., Durham, 1883.
Bennet, Francis Alexander, M.B. et Ch.M., Aberd., 1884.
Marchbank, John, M.B. et Ch.M., Edin., 1876.
Bowser, Henry Charles, M.R.C.S., Eng., 1883.
Stanton, Thomas, L.R.C.S., Irel., 1880; M.B. Dubl., 1881.
Rabl, Heinrich, States Exam., 1880; M.D., Munich, 1881.
Additional Qualifications registered :
Miller, William Francis, M.R.C.S., Eng., 1884; L.R.C.S., Edin., 1883; L. Mid., Edin., 1883; and L.R.C.P., Edin., 1883.

ASSOCIATION INTELLIGENCE.

VICTORIAN BRANCH.

ORDINARY MONTHLY MEETING.

Held at Melbourne, Wednesday, September 10th, 1884.

The President (Mr. Rudall), in the Chair.

THE LATE MEDICAL DEFENCE ASSOCIATION.

THE proposition brought up at the last annual meeting that the Branch should absorb into itself the Medical Defence Association, an organization which, for some years had not exercised any functions, and was practically dead, connected with which there were some unexpended funds, was again submitted. A discussion took place, in which the question was raised as to the power of the Branch to take over the property of the Defence Association. It was shown, however, that, according to the rates of the Defence Association, all right of membership, and therefore of proprietorship, had lapsed, in consequence of the non-payment of subscriptions. The proposition therefore was adopted, and the Treasurer of the Branch was empowered to take over the books, papers, and cash of the Defence Association.

OVERCROWDING OF ASYLUMS.

DR. GRAHAM proposed, "That the attention of the Central Board of Health be called to the report of the Inspector of Lunatic Asylums for the year ending 31st December, 1883, disclosing the fact that on the 31st of December, last year, the public Asylums of the Colony were overcrowded to such an extent as to be dangerous to the health of the inmates, and that this overcrowding still continues contrary to the provisions of the Amended Public Health Statute, and requesting that the Central Board will take immediate steps to stop further admissions to the Asylums until provision be made for the extension or the erection of new buildings for the proper care and treatment of the insane."

This was seconded, and after a brief discussion, carried, and the Honorary Secretary was instructed to forward to the Chairman of the Central Board of Health, and the Chairman of the Lunacy Commission, copies of the resolution.

The following paper was then read :—

ON THE PSYCHOLOGICAL ASPECT OF THE SEXUAL APPETITE.

By JOHN WILLIAM SPRINGTHORPE, M.D., MELB., M.R.C.P., LOND., HON. PHYSICIAN TO THE MELBOURNE HOSPITAL.

THERE are several reasons why a paper bearing on the sexual appetite may well be deemed opportune at the present time, and in this community, even though it attempts little that can be considered original, and proves to be no more than a summary of what many of us already knew. Upon a subject of such importance, and one too frequently neglected or relegated to the nefarious hands of quackery, it is imperative that all at least who as physicians are liable to public and private ques-

tioning, should have fairly comprehensive knowledge and definite views. And in a young colony like ours—one legacy of whose fevered past has been a distinct neurotic tendency, with climatic influences that favour early bodily development, and where the newspapers, by their almost daily tales of sexual crimes, point conclusively to the existence of an extremely grave state of affairs—some general understanding for the adoption of some general line of conduct becomes almost a necessity. Thoroughly convinced then of the need and utility of some discussion into the means best fitted to improve the sexual atmosphere of our rising population, I have ventured to bring the matter forward in an introductory paper, trusting that, though necessarily fragmentary, it may stimulate enquiry and investigation, and tend perhaps to the future discussion of its wider issues by those whose experience and knowledge render them well able to suggest and carry out the needed reforms.

Life, physiologically speaking, may provisionally be defined as the sum of the reactions and inter actions of our nervous mechanism upon its environment, and it is the first object of this paper to show that towards that very complex sum the sexual appetite makes a substantial addition. The rest of the paper will be devoted to an endeavour to trace its influence, somewhat briefly, in the past and to indicate the problem as it is presented to us in our community at the present time.

For the better understanding of our first proposition a brief resumé of the physiology of the sexual organism may be not inappropriate. The two main facts to grasp in such a resumé are the periodicity of the secretion and the dual mechanism of its extrusion. In the woman there is the peculiar and periodic excitement of the ovary, leading to the maturation and extrusion of ovules, with a similar and generally simultaneous excitement of the uterus and appendages, all resulting in the monthly flow known as the catamenia; and, similarly in the man, single sound and continual sufficient secretion has been produced in testes and associated glands in from fourteen to twenty-eight days to cause emission by an action similar in all essentials to that of

menstruation, and similarly varying considerably with age, climate, habits, temperament, diet and predisposition. In both alike abnormality of function is evidenced by excessive frequency or the super-addition of symptoms of nervous implication, as backache, headache, slight mental enfeeblement, depression and languor, much of which, however, is dependent upon individual endowments. Of the differences in secretion between the sexes, perhaps the true explanations are the following:—That in man the flow is physiologically nocturnal, depends probably upon a variety of favourable conditions accompanying sleep, and may be an hereditary endowment. That it is an ejaculation, and not a drain, is the necessary result of the momentary need of the function, and absence of preparation for future pregnancy, whilst the fact that it is most common just before rising is perhaps explained on the hypothesis, that then the peripheral stimulus of sufficient secretion reaches sexual centres when the inhibitory influence is least powerful.

No less important than the fact of periodic secretion is the dual mechanism of extrusion. There are both spinal and cerebral sexual centres, and, according as one or the other is in predominant operation, extrusion may be either excitomotor or sensori-motor. And the importance of a clear conception of the *modus operandi* becomes very apparent when we consider that all attempts at regulating the sexual appetite must be directed either to gratifying the sensori-motor impression normally, or, where that is impossible, favouring the temporary annulment of such impressions, and reducing extrusion simply to the level of an excitomotor action merely—a reflex ejaculation following a stimulus from the secreting organ to the centre in the lumbar region of the cord. It is not difficult to see, though it is frequently forgotten, what a great part in the production of excessive reflex ejaculations may be played by a morbid state of the spinal centre, or of the periphery, just as intestinal stimulation causes diarrhoea and paroxysms of cough follow bronchial irritation. Such morbid local states as phimosis, balanitis, elongated prepuce, urethral catarrh, irritable prostate, a tender spot in the urethra, spasm of the levator ani, varicocele, the irritation of worms or diabetes, and the corresponding states in the female, may make all the difference between functional and excessive discharges. Or from nervous instability, inherited or acquired, the spinal centre may be at fault, and the result is the same over-frequent ejaculation. And in both cases the result is not only excessive drain upon the constitution, but through the sensori-motor mechanism a plethora of sexual impressions sent onwards to the brain centres

which legitimately come under the heading of psychological results of the sexual appetite.

For, coming now to this more special feature of our subject, we find the great anatomical and physiological fact that a very direct means of communication exists between the brain and this spinal sexual centre, whereby the consciousness is informed of the state of the periphery, and messages pass up and down unceasingly. These messages pass upwards in the posterior columns of the cord, possibly in the columns of Goll, but once out of the cord less certainty attends their future anatomical course. The old idea that they were finally distributed to the cortex of the cerebellum may be taken as discarded and almost disproven, its functions being rather motor than sensory. But whether they end in the basal ganglia or proceed on to the cerebral cortex directly, there is no question that the cerebral end of the mechanism is in very intimate connection with the frontal convolutions, and probably more immediately with the cortex of the orbital surface where the later acquired and less fundamental nerve cells are to be found. And, to gain a clear idea of the psychological influence of the sexual appetite, it must be remembered that these frontal convolutions are not only the home abode of the intellectual and moral faculties, but that they are in constant telegraphic communication with the great cortical centres of all the special senses, and with the cortical centres of localized muscular movements.

Into this complex nervous mechanism, then, introduce the various stimuli, organic and external, whose interplay and reactions constitute the basement of our conscious life, and as the machinery is in motion and impression gives rise to sensation, and sensation to ideas and emotions, turn the attention to the part played by the sexual stimulus. In the young, we can see the vague indefiniteness of its beginnings. After puberty it appears with masterful distinctness, and it dies slowly away in the impotence of the aged. But it is a property of nervous matter to register impressions, and in the centres sleep all the intuitions of a past experience, ready to start into life at the word of conscious command, or to fire the explosion that no self-restraint can prevent; and so all through life the sexual appetite must necessarily leave its impressions, which survive even when the function which caused them has grown obsolete. Thus, all through life, a certain proportion of our sensations are necessarily sexual. And when we come to consider the place the sexual appetite holds amongst the various stimuli, we have no reason to limit the range of its influence within narrow bounds, for we find that on its gratification is

bound up the continuance of the race, and as a prime need it is second only to the instinct of self-preservation. It becomes of necessity, therefore, most attractively surrounded, most immediately possible and most willingly fulfilled, and thus as a sensori-motor action, we find it associated with, perhaps, the keenest, most universal, and most imperious of all our sensations, for it is the second highest function of the animal part of our nature. Translated into psychology this means that the sexual appetite plays a part scarcely second to any other in originating and directing our ideas, emotions and volitions; it weaves much of the web of life. Between this appetite as an inheritance from savagery and the place it assumes in the highest modern, in whom it has gathered round it refining influences and high conceptions that have almost transformed it from self-indulgence to self-sacrifice, there is an almost infinite series of degrees, all of which our complex civilization may be said to mirror. We still have men in whom it remains an animal passion, exercised with all the right of might and opportunity. We have men in whom from restraint or cultivation in the higher powers it has become a divinely ennobling force. We have every grade between, from those whose whole atmosphere is discoloured with its influence to those across whose path it falls only in scattered and light-giving beams. Given only a nervous constitution—that is, a brain mechanism peculiarly sensitive to all forms of stimulation, with cortical layers of cells, inherently liable to excessive functional activity—and the psychological aspect of the sexual appetite is as varied as the phases of individual character.

And if a comprehensive retrospect were here possible, a wonderful chapter in the history of our race would be that on the past phases of this powerful instinct. Under the recognised headings of polygamy, concubinage, adultery and monogamy, it will be found to have been one of the most important of our social factors. To ignorant and unnatural attempts after its gratification we would ascribe all the distressing psychology of masturbation and the social evil, and where would such ramifications of its influence not extend? And, descending to the moral chamber of horrors, we would be called to shudder over the bestialities of Sodom, the nameless infamies of Rome and the modern wantonness of Paris. In the rise of Mormonism, in the doctrines of Malthus, we should find instances wherein its influence has reached the dignity of a system. And, turning to the other side of the picture, perhaps the world will never know how much it owes to the reflex of sexual restraint, as exhibited in the asceticism of the monks, in the heroism of

the martyrs, and the foundation of orders of perpetual chastity; whilst the philosophy that dominated Europe for ages—the philosophy that regarded the body as the soul's prison—found much of its strength and many of its arguments in the injurious effect of this irresistible instinct. In our own day it has prompted some of the greatest crimes and aided some of the most extraordinary movements the world has ever seen, and hysteria and insanity are but two prominent points in its orbit of world-wide dimensions and life-long duration. And explain it how we will, it is unquestionable that this appetite is bound up in the same sheaf as our better nature, and that its unnatural gratification carries with it more or less perversion of the higher feelings, and even entire degradation of the moral sense. This may be, as Carpenter suggests, merely an expression of the general laws, that the development of the individual and the reproduction of the species stand in an inverse ratio to each other, but it seems to me more probable that it is from the constant occupation of the mind upon what is essentially selfish that the degradation comes. Eliminate the selfish element from the instinct, or transform it by other considerations as it may be transformed, and there is no antagonism between the individual development and the multiplication of the race—rather the opposite.

But, after all, such a slight retrospect as this can but feebly indicate the enormous influence that the sexual instinct has exerted and is exerting upon our race, according as it has been gratified, misused or annulled. Yet it may serve to arouse the attention to the importance of the problem which at present stares us in the face—how does our present civilization comport itself in the presence of such imperious demands?

In such an enquiry, the first fact to strike the attention is, that civilization has undoubtedly delayed the natural gratification of marriage, and that this delay is to be found especially amongst the large and numerous middle strata of society. Further enquiry discloses the significant fact that, *pari passu*, modern civilization has increased the sensibility of the nervous system to stimuli of all kinds, amongst which sexual stimuli naturally take their predominant place. And, when to this we add that amongst ourselves the nervous system is unusually active, beyond the normal in the old country, whilst the sexual demands are earlier made owing to the earlier bodily development under our sunnier climate, we meet the sexual problem as it presents itself with unusual force upon our own soil, and can understand why, of the three ways in which, practically, moderns meet these demands

—masturbation, the demi-monde and self-restraint till marriage—the two former predominate in our midst to a saddening extent.

Otherwise than very briefly, there can be little need to discuss the relative merits of these different means of dealing with this dominant appetite. In masturbation, though, as Paget says, it is the quantity and not the method that is injurious, and though the chief immediate danger lies in the fact that it is an indulgence that speedily exceeds the bounds of moderation, yet the psychological results are often even more deplorable. Not only may the whole nervous system, in an extreme case, remain at the fatigue point from the excessive drain upon it, but the victim of the habit, though generally vigorous enough to shake off all but the temporary results of simple malaise and irritability, or to escape again and again out of its clouds of caprice, suspicion and gloom may, especially if he be of a neurotic tendency, gradually sink into sexual hypochondria and mental aberration of a very distressing kind. And accordingly we find the writer in Quain's Dictionary of Medicine writing thus weightily: "At no former time was it so necessary as at present for medical practitioners to recognise the evidence of these abuses and excesses, to which are due a large and increasing proportion of the disorders, mental and physical, by which human life is embittered and its duration shortened. Indeed, the evils resulting from this widespread sensuality, the effects of which are seen in our hospitals and asylums, have attained such proportions as to be a subject of national as well as medical importance." The evil results of the second means of meeting this demand—by outside indulgence—are even more striking. It adds to the personal risk of positive disease, the degradation of a woman to an infinitely sad position, and it has another bearing, less apparent perhaps but equally important. It raises the awkward question—if other men's sisters are not wives for us, where are our sisters to find husbands? I have no wish to aim at the desirable but impracticable, and to raise a useless clamour against an evil world-wide, often legally regulated and dating from the Pyramids, but surely this much may safely be said: If, like drunkenness, this is an almost omnipresent evil that cannot be forthwith removed, it can similarly be deprecated in the individual as by no means or upon any ground a necessity for him, but rather in view of its vast potential and often actual mischief, to be shunned as the song of the syrens was of old.

And this brings us to the only sound way in which this appetite can be safely met—by abstinence till marriage—and this imperfect paper will be brought to a close by briefly discussing

how this may be best attained. We have said that our civilization had had the effect of delaying the natural gratification of marriage, whilst it had increased our sensibility to all forms of nervous stimulation, and in this we may see one of the prices that civilization has paid for its imperfection. For had our civilization been perfect, amongst other developments, we should have had an equal counterpoise maintained between the delayed function and the nervous stability. There would have been developed increased powers of resistance to the sexual stimuli, and it is criminal folly to expect that this can ever be obtained by the present plan of allowing the unsuspecting youth to drift within the influence of his passions without informing him of their nature, their use and their abuse, and building up by slow degrees the power of self-restraint.

The first necessity then, after a healthy mechanism, is that a sound knowledge of the sexual organs and their functions should be given judiciously by recognised guardians at or about the age of puberty. It seems incredible, yet is true, that youths and maidens may have a mental grasp of the force of gravitation that binds star to star, and well understand the conservation of energy by which the sun's light becomes our heat, and yet know nothing of the laws, extent, and operations of a force within them that may, nay must, sway them as the saplings of a forest before the winter's storm—a force upon whose blind issues the die of their life is cast. Grubbing for Greek and Latin roots, they never raise their eyes to the divine Greek inscription, "Know thyself," but they are allowed to come within what might almost be called the maelstrom of their unsuspecting and unwarmed passions, and become slaves where they should have been masters. And, as the climax of this necessary sexual education, we might lay down as a general rule, with but few exceptions, two golden maxims as worthy of general remembrance—marriage when practicable, and, till marriage, self-restraint. The former we leave to the teacher and the statesman, for marriage we know depends very much upon prosperity, and prosperity, within limits, upon statesmanship; but the second question of self-restraint until marriage is peculiarly the province of the physician.

Where, then, we can be accessories before the fact, we should, if possible, use our influence that the child's inheritance should be a healthy frame; during childhood it should be maintained at a high degree of excellence, and about puberty, and especially in the neurotic, it should be carefully examined and by degrees judiciously taught its sexual physiology. Hence onwards until

marriage the excito-motor mechanism should be the subject of investigation and regulation, so that none but the normal impressions might travel upwards to the brain. To this end it might be necessary to snip off a redundant prepuce, divide a contracted meatus, clip a short frenum, remove internal and open external piles, divide rectal fissures, treat herpes pruritus hyperaesthesiae, suspend varicocele, attend to diet and bowels, empty the bladder both before sleep and on waking, etc., and the same, *mutatis mutandis*, in the female. Then the state of the periodic secretion in cases of ill-health should be enquired into, and by appropriate means directed to the normal. Thus much of the excito-motor side of the appetite. The sensori-motor portion, in its turn, will require careful and continued attention, and, as being the higher, its regulation is a matter of supreme importance. It may be treated negatively and positively, part of the system consisting of "don't," the rest of "do," and a recollection of this twofold treatment becomes practically the more necessary when we remember that the mental faculties can be predominantly directed to only one thing at a time, and attention to one class of phenomena excludes the presence of another. Thus all sexual stimuli, except the physiological, are to be avoided, and all causes of sexual sensorial stimulation are to be minimized, both sensory and ideational. Dalliance, erotic literature and pictures must be given up, or sensory stimuli will make their inevitable result. Chastity of mind must be cultivated, or lascivious thoughts will react downwards upon the lumbar centre. And positively also, by filling the mind and sensorium commune, with other impressions, ideational and sensory, we can not only prevent the access of sexual phenomena into the brain cells, and their registration there to originate fresh sexual ideas or facilitate old sexual actions, but we can build up a cortical resistance to the less used sexual stimuli, and lay the foundation of a nervous colony, originating non-sexual actions and gratified by non-sexual impressions. This Carpenter briefly epitomises into "study and gymnastics." In reading this to mean, keeping mind and body pleasantly occupied in ways varied indefinitely to meet the infinitely varied learnings of the individual, this advice summarises all but the distinctly medicinal treatment, which may be necessitated by bodily ill-health, or by sexual lapses. Into this part of the treatment, which consists in the use of sedatives and tonics according to necessity, there is no need for me to enter.

But, after all, it is well in most to remember that all the foregoing are but expedients, necessary as an honest consideration shows them to be,

but still expedients until the instinct meets its natural gratification in marriage, or by development becomes metamorphosed into something quite different. Whatever the future may disclose—and who shall place limits to its expansion—for the present, at any rate, marriage for most men is not only advisable, it is a necessity. "To be fruitful and multiply" remains still one of man's prime physiological needs, and marriage is its true goal. The same lesson seems taught even by the decaying civilizations of India and China, where all other considerations have given way before the universal custom of early marriage. And, thanks to the expansion of England over every quarter of the world, we too may follow their example without paying their price for it, or having to ask ourselves whether its necessary outcome must be malthusianism and infanticide. With us the practical question in relation to this still predominant appetite is how to discourage the lower forms of meeting it, and how to strengthen the higher. Much mischief is here undoubtedly done by the present system of misguided silence upon the subject from its supposed delicacy, and no doubt it will form part of the improved education of the future to place this natural appetite upon its real footing and bring it under due subjection to its temporary annulment. For once show the real dangers of the indulgence and the reasonableness of the restraint, and the battle would be half won, whilst in a widespread knowledge of the value and necessity of such a temporary self-mastery lies perhaps the only cure for the social evil and all its miserable surroundings. And, in view of the magnitude of the issues at stake, and the low sexual condition of a large portion of our community, surely the time has arrived when some professional discussion should take place and out of the multitude of counsellors some wise course of conduct be adopted. In a matter of this delicacy speech may be difficult and action liable to misrepresentation, but non-interference will finally bring reproach as well as calamity, and the difficult path may be the path of duty and honour. I have aimed at clearing the ground of preliminary obstacles in briefly reviewing the range and influence of the sexual appetite, and in pointing out what seems to be the one way in which it should be met, and I now leave the larger and more practical issue of how best to improve the sexual atmosphere of our rising population, with its various ramifications and intricate details, for the judgment and discussion of the members of this association, with the hope that personal effort may be stimulated, even if public action be deemed inadvisable.

In the discussion which followed,

Dr. McMILLAN thought the paper bore evidence of great thought and original enquiry. The subject was one which was commonly avoided; but it was beginning to be felt that its neglect, from notices of over delicacy, was an error of judgment, and the introduction into schools of the study of physiology showed that the value of instruction, having reference to the reproductive organs was beginning to be recognised. The inclusion of physiology into the curriculum of the American schools, was a noteworthy feature of progress in the educational system thus pursued. Much of this teaching, however, might he thought, be accomplished in connection with home-training, and it was the duty of mothers to see that their daughters comprehended the nature and the importance of the sexual organs and their functions. He desired to protest against the encouragement given by some medical men, to the belief that sexual intercourse was a necessity. No doubt a good deal of such alleged necessity depended somewhat upon circumstances, and especially upon temperament. He was satisfied, however, that absolute sexual continence was compatible with perfect health. He regretted that the moral and religious influence was too often overlooked by medical men, when advising patients as to the advisability or otherwise of indulging in sexual intercourse. Parents, he thought, left counsel of this kind too much to ministers of religion. The instinct of abstinence ought to be encouraged.

Dr. HENRY complimented the author of the paper upon having dealt with a delicate subject in a philosophical and scientific manner. Dr. Springthorpe, however, had hardly laid sufficient stress upon the importance of diet in determining the sexual appetite. In this colony, by far too great a quantity of animal food was eaten, and this excess of nitrogenous material in the system, intensified, especially in the young, the sexual desire. He quite concurred with Dr. McMillan in the importance to be attached to physiological teaching in schools. With reference to the power of the mind over the body, in controlling sexualism, he referred to a French physiologist, who advised those afflicted with nocturnal orgasms, to throw from them with disgust just before slumber, any libidinous picture in their possession. The impression of dislike would be continued during sleep, and the person affected would probably awake at the moment the image, provocative of desire, presented itself in dreams. He referred to the practice of the Spartans who permitted young people to associate much together uncovered, a practice which had the effect, by reason of familiarity, of rendering them sexually indifferent to each other. The Monks of the middle ages, by long and determined sexual abstinence, were said to have caused atrophy of the testes. It was possible, however, that the practice of masturbation had some share in this result. He had certainly observed among the prisoners effects of this kind from that cause.

The PRESIDENT thought Dr. McMillan's remarks upon the practice of advising unmarried patients to indulge in sexual intercourse very pertinent. There was always the risk of syphilitic or gonorrhoeal infection, so that continence was much the safest course to pursue. With reference to the sexual appetite in women, he might observe that some physiologists held it as demonstrated, that menstruation was independent of ovulation, and that the latter occurred at a much earlier period than was generally supposed.

Dr. JAMIESON remarked that it was now an established conclusion, that ovulation and menstruation were independent of each other, and that they were functions not of necessity connected.

Dr. SPRINGTHORPE having briefly replied, the next paper was read.

ON SOME POINTS IN THE TEST FOR ECCHYMOSIS.

By JAMES EDWARD NEILD, M.D.

I MADE a *post-mortem* examination of the body of a man the other day, and upon the neck, chest and left leg there were large discolourations which, at first, I took to be ecchymoses. I employed the customary test, and cut freely into the skin, and the blood flowed therefrom copiously. The edges of the discolourations, however, were not raised, and the tint was exactly that of hypostases; I therefore turned the body over, and cut into the skin of the back, which was very deeply coloured with hypostatic stains, and I found that an equally copious flow of blood came from these incisions. The body I knew had not been other than in the supine position since death, and, therefore, the anterior stains could not have been caused by gravitation of the blood. They were not, in fact, hypostases. The body was that of an inmate, aged 51, of the Yarra Bend Lunatic Asylum. It was stout and generally well nourished. The brain was in the commencing stages of softening, and the thickening and opacity of the arachnoid were more than ordinarily well marked. The blood was distinctly fluid, and between the dura mater and the arachnoid, especially on the right side, there was a thin laminar, not firm coagulum of blood, which had evidently been effused through the capillary vessels, and not extravasated by the rupture of any artery. It appeared to me, therefore, that the fluid condition of the blood had rendered it favourable for osmosis, and that both the discolourations in the skin and the laminar coagulum within the skull were due to a process of osmosis. The kidneys were in an advanced stage of granular disease, the left one being much atrophied and containing within its pelvis about a drachm of pus.

The practical point in this case is the resemblance of these pseudo-ecchymoses to true ecchymoses, and the risk in confounding them with these latter. In this case it happened that there was distinct evidence to demonstrate that these marks on the front of the body had not existed before death, and there was also the exceptional condition of the hypostases on the posterior aspect of the body, helping one to the proper explanation of their nature. But I can readily imagine a case in which a person, say a child, had died with some suspicion of ill-usage against those under whose care he had been placed. A number of apparent bruises found on the body having responded to the cutting test, might easily enough be pronounced to be true ecchymoses, and a charge

of ill-treatment could thus easily be made, and quite as easily substantiated. I apprehend that such cases as this now described are rare, as this is the only one of the kind I have met with. I never before knew blood to flow from an incision made into a hypostasis, and, although I have seen a great many pseudo-ecchymoses, the test of a free incision into them has always revealed their true character.

In the discussion which followed,

Dr. BRETT thought that the existence of diseased kidneys with albumenuria, might offer an explanation of the readiness of the blood to pass by osmosis through the capillaries. He mentioned a case which had come within his knowledge, in which the mere rubbing of the bedclothes produced discolouration of the skin.

The PRESIDENT thought it probable that from the venal disease, there had been uræmic poisoning, and that the disorganisation of the blood, so occasioned, had been favourable to osmosis.

Dr. NEILD added that the man had died comatose, and that although there was brain-softening, with a good deal of serum in the lateral ventricles, the comatose condition in which the man died, might be partly due to uræmia.

EXHIBIT.

Samples were submitted of Aix-la-Chapelle Thermal Water forwarded by Messrs. Haeger and Co. A report of the analysis of the water accompanied the exhibit. This was as follows:—

This water contains in 10000 grammes or 10 litres :	
1. Chloride Sodium	26.161
2. Bromide "	0.036
3. Iodide "	0.006
4. Sulphide "	0.136
5. Sulphate Soda	2.836
6. " Potash	1.527
7. Carbon. Soda	6.449
8. " Lithion	0.029
9. " Magnesia	0.506
10. " Lime	1.579
11. " Strontia	0.002
12. " Iron Oxide	0.095
13. Silicic acid	0.662
14. Organic matter	0.769
Grammes	40.791

The water was pronounced by those who tasted it to be extremely palatable, and its chemical constituents were considered to fit it for tonic and alterative purposes.

NEW SOUTH WALES BRANCH.

The 45th General Meeting of the Branch, was held in the Royal Society's Rooms, on Friday, 5th September, at 8.15 p.m. Dr. Quaife, President, in the chair. Dr. Kendall was present as a visitor.

The President announced the following new member, Dr. J. S. Wilson, of Wilcannia.

Dr. J. C. Cox read some notes on "Three Cases of Pelvic Hæmatocele," and Dr. Scot Skirving a paper on "The Induction of Premature Labour in a case of Dangerously Exhausting and Obstinate Vomiting;" both these papers were published in our last issue.

A discussion then ensued, in which Drs. Fortescue, Crago, Creed and J. C. Cox took part.

Dr. Crago also exhibited four pathological specimens and read some explanatory notes concerning them.

The meeting then terminated.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

**AUSTRALASIAN
MEDICAL GAZETTE.**

SYDNEY, OCTOBER 15, 1884.

EDITORIALS.

**THE AUSTRALASIAN SANITARY
CONFERENCE.**

In this number we publish a report of the proceedings of this Conference, which includes the series of sixty-seven resolutions, the summary of their work. These resolutions will place before the Governments and Parliaments of the various colonies, in a tangible form, the opinions of representative men as to what is necessary to be done to minimise the risk of the introduction of fresh diseases into Australasia, at the same time to reduce the cost and inconvenience to the shipowners as much as possible. This is the first step towards that federation which must prove of such vast advantage to all the colonies, and it is to be hoped that similar action in other matters will quickly follow. In the meantime, the medical profession may fairly claim credit as being the advance guard in this desirable issue. As it is, the matter cannot be settled by any central legislative body, but to carry it into practice it will be necessary to institute special legislation in each Parliament. We think the outports are well chosen, and there can be no debate as to that on the west, viz., King George's Sound, as to Lizard Island, with which we have some personal acquaintance—it is in every way suitable, is large enough, sufficiently sheltered, well enough grassed to carry some small quantity of live stock, and is isolated; but, should settlement extend further up the Cape York Peninsula, it will not be quite on the outskirts of the inhabited portion of the continent. With regard to the

advisability of enforcing compulsory vaccination and re-vaccination in the whole of the colonies we are fully in accord, but whether it will be practicable to carry it into effect remains to be seen. We are informed that many of the steamship lines trading to the United States insist on their intending passengers either producing a certificate of recent successful vaccination or submitting to be vaccinated, that the detention of the steamer through small-pox breaking out on the voyage may be avoided.

**THE HON. DR. BEANEY, M.L.C., ON
THE CONSEQUENCES OF VACCINATION.**

In a motion moved by this honourable gentleman in the Legislative Council of Victoria, for the appointment of a Royal Commission to take evidence and report upon all matters relating to the public health, &c., he indulged in some very rash and characteristic statements as to the terrible evils of vaccination with humanized lymph. It is possible that occasionally ills do arise as a consequence of vaccination, but they are extremely rare, and if practitioners who do not aim at a temporary notoriety, perhaps only to be obtained by some violent difference of assertion (we do not say opinion) from their professional brethren, are asked to give their experience, it will be that they have never, or but very seldom, seen the diseased state which has followed vaccination really proved to have been a consequence of it, the evidence being when sifted generally in favour of its having arisen from some other cause. Dr. Beaney's statement, as reported in the *Argus*, is vague and rash, and unworthy of a man of standing in the profession. He should, in the interests of the public, not make mere assertions, but should give good histories of the cases, with the symptoms and reasons which led him to think that the diseases which he says necessitated amputation of the leg in one case and lower jaw in another, resulted from the use of impure lymph. These cases, we presume, are on record, and if he will send them to us we shall be happy to publish them, that the correctness of his pathology may be discussed by our professional readers generally.

CLINICAL INSTRUCTION TO STUDENTS IN HOSPITALS.

A DEPUTATION from the Melbourne University, headed by the Bishop of Melbourne, recently waited on the Hon. Jas. Service, Premier of Victoria, asking that the Government grant in aid of hospitals should be allowed only on the proviso that proper clinical instruction is given by the staff of the hospital to the students attending practice there. This, we think, is but a fair and reasonable request, for without it we fear that clinical instruction will often be imparted in such a perfunctory manner as to be practically useless. It is not too much to ask that if the community provide funds for the maintenance of a hospital, the former should receive some return in the proper practical training of the individuals, who at some future time are to figure as medical practitioners in it. A hospital can easily arrange that its staff shall give the necessary instruction at fixed times and in a proper manner by making it a condition of appointment, of course providing that the lecturers are properly remunerated from the fees paid by the students for hospital practice. The hospital itself would be repaid by the improvement in the services rendered by the students as dressers, clinical clerks, and the like. We commend the request of the deputation to the consideration of the Governments of all the colonies having at present, or who are contemplating the establishment of, a medical school.

THE Editor is in recent receipt of a letter bearing date Aug. 31, 1884, from Dr. B. W. Richardson, F.R.S., the eminent hygienic authority of England. In it he says, "I am often tempted to take a run over to your country, and my good friend, Sir Henry Parkes, held out such ideas of a kind reception, I sometimes contemplate the visit." We can only say how honoured and pleased we should feel by such a visit, and we are confident that in saying this we are only expressing the sentiments, not only of the medical profession, but of all the leading and thinking men of Australasia. The gain to the future sanitary welfare of these colonies from the visit of such a high authority would be incalculable.

THE TAMWORTH HOSPITAL.

IN the *Tamworth News* of October 10 appears the report of the usual monthly meeting of the committee of the local hospital. It reveals a most peculiar state of affairs, which is a disgrace to all concerned, and urgently calls for the attention of the Inspector of Public Charities. The committee apparently have no funds; one of their body is, it seems, in the habit of furnishing supplies to the institution of which he is one of the governing body, and those members who are the most violent and unscrupulous in their conduct and language appear to be allowed to exercise the most influence. We can only recommend members of the profession who are possessed of honourable and gentlemanly feelings to as far as possible avoid all contact with this institution. Those men who do not possess these characteristics may do as they please without protest from us, and will probably have fitting associates.

DR. COCHETRY, of Dunedin, is at present in Sydney, having been entrusted by the New Zealand Government with a mission of enquiry as to the precautions and sanitary arrangements adopted in the Australian colonies for the prevention of disease, with a view to their comparison with those in force in the former colony.

THE following paragraph, taken from the *London Times* of August 7, 1884, showing that two out of six gentlemen to whom the honorary gold medal of the Royal College of Surgeons has been awarded since its foundation in 1800, are resident in Australia, will, doubtless, be of interest to our readers:—"The members of the medical profession will be glad to learn that at a meeting of the Council of the Royal College of Surgeons on the 5th inst., the honorary gold medal of the College was awarded to Sir William James Erasmus Wilson, LL.D., F.R.S., F.R.C.S., &c., in recognition of his great liberality in his contributions to the museum, in the endowment of the Pathological Curatorship, and in the foundation of the professorship with which his name will always be associated. Since this medal was founded in 1800 it has only been presented to six gentlemen, viz.:—Mr. James Wilson in 1800, Mr. James Parkinson in 1822, Mr. Joseph Swan in 1825, Dr. George Bennett, of Sydney, in 1834, Mr. William L. Crowther, of Hobart Town, in 1869, and Dr. T. B. Peacock in 1876."

LEADING ARTICLE.

APOMORPHIA.

BY J. ASHBURTON THOMPSON, M.D. (BRUX.),
SAN. SCI. CERT. (CAMB.), SYDNEY, N.S.W.

IN the *A. M. Gazette* for September a contribution by Dr. Joseph Bancroft, of Brisbane, is published, in which the writer testifies to the value of emesis in the treatment of the earlier stages of sunstroke. He concludes by saying that he feared to use apomorphia to cause vomiting in these cases because, in some experiments made upon mice, he had been unable to assure himself that it differed in its narcotic properties from morphia. I do not feel the force of this objection, if, for a moment, it be supposed to be well founded; both because the physiological action of morphia is, in many respects, opposed to the physiological effects of sunstroke, and because morphia is actually used in India in some cases of sunstroke with results which are favourably spoken of (Fayrer, Practitioner, 1876.) A possibly sound objection to its use in these cases (in which the tendency is to death by syncope) might be found in the effects of quite another kind which apomorphia has occasionally produced; but to these Dr. Bancroft does not refer.

It is not the treatment of sunstroke; however, upon which I wish to write. Apomorphia is now generally acknowledged to be—as I too have found it—one of the most useful emetics at our command. It is the promptest in action, and the least disturbing or depressing. It is moreover, under certain circumstances, an invaluable expectorant; and for both purposes it is especially useful in the treatment of children. The cases in which vomiting is desirable are often those in which narcosis may not be risked; in those in which it is necessary to promote expectoration, narcosis would be fatal; while in cases of whatever kind, if they occur to children, narcotics are properly administered only with very great caution. It seems worth while, therefore, to point out that the similarity between the words morphia and apomorphia does not extend to the physiological effects of the things themselves.

Apomorphia, or, more exactly, the hydrochlorate of apomorphia, was discovered by Matthiessen, who obtained it by heating morphia and strong hydrochloric acid in a closed tube at 140° to 150° F. for several hours; the solution was then precipitated with bi-carbonate of soda, and afterwards treated with chloroform or ether, the apomorphia obtained being about 5%, by weight of the morphia used. He announced that a grain caused vomiting, without harm, when administered to

man. Dr. Gee, in England, first put it to practical use, in 1869. Dr. Chouppe (*Gazette Hebdomadaire*, 1874) thus describes its effects:—For two or three minutes after the injection the patient feels nothing new; he then has a feeling of weight about the stomach and a slight pain in the head; salivation and perspiration set in and are followed by one or two futile attempts at vomiting; by the end of four minutes from the administration the contents of the stomach are expelled without effort, but with some violence. There is then a complete cessation of all symptoms. During half an hour at the most the same symptoms are repeated once or twice. The patient then doses a little, but at the completion of an hour all symptoms have passed away.—To this account it must be added that the pulse is quickened, and that the respirations increase in rapidity, and lose in depth, as the nausea increases; afterwards the pulse falls below the normal for three or four hours (Von Siebert.) The same observer says that the blood-pressure is unaffected throughout; however, Dr. Reichert's careful physiological observations seem to show that there is always both a primary and secondary fall, as is more probable. Clinically, these effects generally, or at all events often, escape observation. There is always acceleration of the pulse rate; but, in children especially, most often no sign of approaching vomiting can be detected, and in from two to four minutes from the injection the contents of the stomach are quite suddenly and completely ejected. For the physiological effects of apomorphia, as given by Reichert from an experimental study of its action upon animals, which are highly interesting but not of sufficient clinical importance to be given here, see the *Philadelphia Medical Times*, 1880.

Thus it appears that, clinically, the effect of apomorphia is quite different to the effect of morphia. It has occasionally been recorded—perhaps half a dozen times altogether—that the hypodermic injection of this drug has given rise to alarming syncope. Apomorphia is a cardio depressant; but this power is manifested in the doses usually employed so slightly that it cannot for the most part be observed. It is conjectured, therefore, that the alarming depression which has been seen, although very rarely, is more probably due to impurity of preparation than either to idiosyncrasy or to contra-indications which had been overlooked. I have never witnessed any approach to this effect, which, I am satisfied, is negligible.

The dose is generally fixed, for an adult, at 1-30 of a grain by hypodermic injection, to produce vomiting. Dr. Duncan (*New York Medical Record*, 1875), says that for children from 1½ to

8 years of age 1-50—1-25 of a grain is sufficient. Practically, 1-6 of a grain is administered to adults, and for children I take less than the half of a solution of this quantity without being careful to measure it exactly. Taken by the mouth it is useful in the first stage of bronchitis, when the cough is dry; and in the stage of resolution in broncho-pneumonia, as an expectorant. It may be dissolved with a very little diluted hydrochloric acid and combined with syrup and gum. The dose for children is 1-32 of a grain, and adults may take 1-8 of a grain—the former every two hours, the latter every three or four hours; and by the mouth these doses do not nauseate.

AUSTRALASIAN SANITARY CONFERENCE.

THE first meeting of the Australasian Sanitary Conference of Sydney, 1884, was held in the Executive Council Chamber on Wednesday, September 17. Delegates present:—For New South Wales: Dr. Mackellar (Medical Adviser to the Government); special delegate, Dr. Ashburton Thompson. For Queensland: Dr. Bancroft (chairman Medical Board). For South Australia: Dr. Paterson (Colonial Surgeon). For Tasmania: Dr. Turnley (Quarantine Health Officer). For Victoria: Dr. M'Crea (late Chief Medical Officer). For the Crown colony of Western Australia: Dr. Rogers (Quarantine Health Officer). In the absence of Dr. Corney (Acting-Chief Medical Officer) to represent Fiji, the Government of that colony requested Dr. Mackellar to represent them at the Conference, which he accordingly did.

The members of the Conference having been welcomed by the Colonial Treasurer, that gentleman retired and business was proceeded with. Dr. Mackellar was unanimously chosen as president of the Conference, and Dr. Ashburton Thompson was appointed to act as secretary. A number of "articles" were adopted, amongst them being one affirming the desirableness of having uniform laws dealing with matters relating to health, another to the effect that special measures should be taken to ensure the departure of immigrant vessels under such conditions as shall ensure freedom from infectious sickness during the voyage, and a third to the effect that each vessel should bear but one bill of health, which should be endorsed at each port of call. The Conference also recommended the adoption of the international bill of health, and consider that the fact of any vessel bearing a clean bill of health should not necessarily prevent sanitary inspection. In the afternoon the members of the Conference visited his Excellency the Governor.

THURSDAY, SEPTEMBER 18.

All the members were present, and the proceedings lasted for five hours and a half. The first business considered was the question of admitting the press, which subject was reopened by Dr. M'Crea, the Victorian delegate, and on his motion the reporters were allowed to be present at the proceedings. The principal subject

of discussion was the establishment of outport quarantine stations, more especially at King George's Sound and somewhere in the North, where vessels passing on to other ports and having infectious or contagious disease on board, should land their sick and suspected cases, so as to allow of their proceeding on their voyage and dating their time of quarantine from their last contact with the diseased or suspected passengers. This proposition was unanimously agreed to as being not only advantageous to the shipowners, but to the passengers remaining on board, and the other colonies which thus had the danger of infection reduced as much as possible. The question of inspecting vessels trading between colonial ports when virulent infectious disease was present in the colonies, was then considered, but subsequently abandoned on the ground that while there was no inland quarantine, it was no use carrying on maritime inspection. The Conference also gave an expression of opinion in favour of obtaining through the Agents-General all possible information from London as regards the health of foreign ports.

FRIDAY, SEPTEMBER 19.

The Sanitary Conference met again at the Executive Council Chamber and sat for three hours. Hitherto it has been called the Intercolonial Sanitary Conference, but "Australasian" was substituted for "Intercolonial" by special resolution as being far more specific. It was agreed that the Agents-General of all the colonies should forward all possible information as to the health of foreign ports to some central point in Australia, whence it could be diffused throughout each colony, and following upon this resolution a discussion took place in reference to the exclusion of Chinese to prevent the spread of leprosy, it being ultimately agreed that a special examination should be made of all ships coming to Australian ports and having Indian coolies or Chinese on board, with the view of preventing the landing of any leprosy persons. The only other subject discussed was that of vaccination, upon which both Dr. Mackellar and Dr. M'Crea (of Victoria) spoke with considerable precision, advocating compulsory vaccination in all the colonies, and at 1 o'clock the discussion was adjourned till the next morning. In the afternoon Dr. Mackellar invited the members of the Conference and a party of other gentlemen (including the Colonial Secretary, the Treasurer, Drs. Creed, Fortescue, MacLaurin, West, and the Mayor of Sydney) to a trip down the harbour, the quarantine vessel *Faraway*, temporarily moored off Lavender Bay, being visited first. Luncheon was served on board her, and some toasting indulged in before the trip was proceeded with. Middle Harbour, the Quarantine Station at a distance, and Rose Bay were visited before the party returned to the city, charmed with the fine afternoon's outing.

SATURDAY, SEPTEMBER 20.

Discussion was resumed upon the question of compulsory vaccination, and a resolution was unanimously agreed to, urging the necessity for the enactment of legislation to that effect in all the colonies without delay. Proceeding with small-pox subjects, the Conference defined an infected vessel as one carrying a case of the disease on the voyage, and then considered what abatement of quarantine should be allowed to those persons who, on arriving in an infected vessel, could satisfy the health authorities of recent re-vaccination. It was decided that such persons as had been re-vaccinated not more than six months prior to their arrival should be released after disinfection, at the discretion of the authorities, in not less than three days. It was also resolved that persons arriving in an

infected vessel, not being infected themselves, should be re-vaccinated. The remainder of the sitting was occupied with the discussion as to when persons vaccinated at the quarantine station should be released. Dr. M'Crea, of Victoria, strongly insisting that he had proved 14 days' quarantine was ample security in all cases against small-pox. Dr. Mackellar joined issue with him upon this point, considering 21 days should be prescribed for all persons who took no precautions whatever to secure themselves against the disease, while 14 days would be sufficient for persons who were re-vaccinated on arrival. The discussion was ultimately adjourned till the next meeting of the Conference, on Tuesday following.

TUESDAY, SEPTEMBER 23.

The Australasian Sanitary Conference resumed its sittings at the Board of Health Office, and worked hard at the framing of suitable quarantine regulations in the cases of small-pox, cholera, and yellow fever. In the case of small-pox, it was decided that the detention of passengers whose re-vaccination ran a normal course should be limited to 14 days, and the same limit was placed upon those who proved insusceptible to the influence of vaccine lymph. As Dr. M'Crea remarked that persons could be vaccinated four times within that period, it is probable that the insusceptible ones will not escape sore arms in any case. Those persons refusing to be vaccinated will be detained at the pleasure of the health authority for any period not less than 21 days. This is a severe provision, but when it is considered that the persons it affects form a selfish class, which secures its own comfort at its neighbour's risk, it will not be thought too much so. A long debate followed as to the time of detention in cases of cholera. It appeared from the information furnished on the subject by Dr. Thompson, that in Alexandria a quarantine of 10 days was imposed where the regulations were unusually strict, and of four or five days only at the port of New York. Dr. Thompson was in favour of a 10 days' quarantine, and Dr. M'Crea would support one of 14 days. Dr. Mackellar earnestly advocated that the period should be one of 21 days, and although Dr. Rogers opposed the motion as laying down a course of procedure for which that adopted in other parts of the world afforded no warrant, the three weeks' quarantine was ultimately agreed to without opposition. In the matter of yellow fever, a ten days' quarantine was named, after which, the less frequent cases of infectious fevers having been discussed, the Conference separated. The sitting was a long one, and the members of the Conference, by a close attention to the matters in hand, got through a great amount of work.

WEDNESDAY, SEPTEMBER 24.

The Australasian Sanitary Conference held a morning session at the Executive Council Chamber when the question of quarantining against measles, scarlet fever, typhoid fever, whooping cough, and similar diseases was considered. It was resolved that as no measure of federal quarantine was likely to prove generally successful in such cases, the health authorities at the port of destination of passengers and vessel should have discretionary power to detain the sick and their attendants, and to disinfect the portion of the vessel occupied by them. Dr. Rogers strongly urged upon the Conference to adopt the Western Australian practice of applying the same principle of quarantine in all these cases as was applied to small-pox, cholera, and yellow fever; but he was alone in his advocacy. A resolution was also carried in favour of quarantining all imported dogs for not less

than six months, to prevent the introduction of rabies. The remainder of the session was occupied with statements as to the different modes of disinfection of clothes and bedding, in the course of which Dr. Mackellar remarked that he had suggested to the Government the propriety of establishing a public steam laundry, where poor people could have their clothes properly cleansed at a nominal cost.

THURSDAY, SEPTEMBER 25.

At this day's meeting the question of quarantine outports was discussed, and on the motion of Dr. M'Crea, seconded by Dr. Rogers, it was decided that the quarantine outport to provide for vessels approaching Australia from the west, should be fixed at King George's Sound (W. A.), and on the motion of Drs. Bancroft and Rogers, it was carried,—"That the federal quarantine outport for vessels approaching Australia from the northward should be established at Lizard Island, or at any other island which may be preferred by the Queensland Government."

With reference to the number of sick to be provided for at these sanitary stations, it was resolved on the motion of Drs. Mackellar and Rogers—"That the permanent establishment at the Federal quarantine outports should consist of hospital accommodation for 30 persons, together with the buildings necessary for the permanent staff. That there should be provided at the Federal quarantine outport provision for the temporary accommodation on shore of 600 persons, in order that all persons may be removed to the shore, whenever that step should be found necessary for the effectual cleansing of the vessel."

FRIDAY, SEPTEMBER 26.

The Australasian Sanitary Conference met again for a morning session at the Executive Council Chamber, when the question of quarantine outport stations was further considered, and an estimate prepared of the probable cost of each. The total cost of equipment for a station with 30 beds and temporary accommodation for 600 persons was put down at £12,000, which, as the Conference has already decided, would be provided by the different colonies joining in the Federal Quarantine scheme in proportion to their population. A resolution was also carried in favour of the compulsory registration of the milder forms of infectious disease, such as measles and scarlet fever; all the members of the Conference, except Dr. Rogers, of Western Australia, supporting the recommendation that the householder, and not the doctor, should give information of the outbreak of disease. Arrangements were made in the afternoon by Dr. Mackellar to allow the members of the Conference to inspect the steam laundry at the quarantine ground, which apparatus is removed from where the small-pox patients are housed.

SATURDAY, SEPTEMBER 27.

The resolution passed at the previous sitting relative to the compulsory notification to the authorities by a householder of infectious disease occurring in his house was reconsidered and amended, so as to make it incumbent upon the physician to inform the householder of the nature of such disease, this provision not being included in the original resolution. The various quarantine laws of the colonies were conversationally discussed up to 1 o'clock, and it being understood that Dr. Rogers would have the superintendence of the preparation of the quarantine outport at King George's Sound, Dr. M'Crea mentioned incidentally that it would be well if a member of the Conference performed the same duty with reference to the proposed

station on the coast of Northern Queensland, and he suggested that Dr. Ashburton Thompson, who possessed the necessary qualifications, should be named to the Queensland Government in that connection. The Conference favoured the suggestion.

In the afternoon, under Dr. Mackellar's guidance, the delegates inspected the Coast Hospital at Little Bay, and on Sunday they were shown over the suburban lunatic asylums by Dr. Manning. In the evening the members of the Conference were entertained at dinner at the Australian Club by the Colonial Secretary and the Attorney-General.

TUESDAY, SEPTEMBER 30.

The Conference concluded its sittings this day, when all the delegates attended at the Board of Health Office, to confirm their past proceedings. The resolutions agreed to from time to time were reviewed, and several amendments made in them, chiefly of minor importance. In the matter of quarantining for cholera, however, the period of detention was reduced from 21 to 10 days, and New South Wales was named as the colony which should receive for subsequent distribution among all the colonies the information to be gathered by the Agents-General in London relative to the health of foreign ports. Two new resolutions were added to those already passed. On the motion of Dr. M'Crea, seconded by Dr. Turnley, it was resolved,—“That in the opinion of this Conference, in order that the federal quarantine outposts may be constructed in accordance with its intentions, the general design of each port should be entrusted to one of the delegates, who from having taken part in these proceedings is most competent to select the site, plan the establishment, and superintend its construction; and that in the case of Queensland he should visit any place which may be recommended by the Government of that colony as a site for the purpose.” It was further agreed to recommend, on the motion of Dr. Rogers, seconded by Dr. M'Crea, “that the expense of the maintenance of persons landed in quarantine at outposts should be borne by the owners of the vessels.” The minutes embodying all the resolutions passed by the Conference, were then confirmed and signed by each of the delegates; and at half-past 4 o'clock the Conference closed. With regard to the report to be submitted to the various Governments of the colonies, its preparation will be entrusted to Dr. Mackellar, the chairman, and Dr. Ashburton Thompson, the secretary of the Conference, whose draft will be submitted for approval to the other delegates, and then finally adopted.

THE RESULT of the Conference is embodied in the following resolutions unanimously approved of by the Delegates, at the 10th Session, held on September 30th.

TITLE.

1. That this Conference be named “The Australasian Sanitary Conference of Sydney, N.S.W., 1884.”

DEFINITIONS.

2. That the word “vessel” or “ship” in these proceedings shall be interpreted to mean the vessel and all persons and things on board.
3. That by Quarantine this Conference understands such measures taken in regard to vessels coming to the various Australasian ports as will effectually protect the Australasian Colonies from the invasion of contagious or infectious disease consistent with the least possible interference with the liberty of individuals and with the least possible restriction to commerce.

4. That a vessel infected with small-pox is one which has carried a case of that disease during the voyage.

PRINCIPAL RESOLUTIONS.

5. That since Australasia consists of adjoining territories and adjacent islands which are remote from the rest of the world but are in daily communication with each other by railways and steam-vessels it is desirable that the several Governments should agree in their laws and practice of Quarantine.
6. That it is desirable to have accurate information of the state of the public health in the exporting country and in ports touched at upon the voyage.
7. That special measures should be taken to ensure the departure of immigrant vessels under such conditions both as regards crews and passengers as shall ensure freedom from infectious sickness during the voyage.
8. That when a port is declared infected it should be gazetted by all the Colonies simultaneously.
9. That it is desirable that the various Governments should be accurately informed of the state of the Public Health in the Colonies respectively under their control.
10. That measures should be taken by each Colony to secure the health of the people and to obtain the earliest information of the presence and prevalence of infectious disease among the latter.
11. That matters affecting the Public Health should be made known by each Colony to every other and that this should be done by direct communication between the Medical Advisers to the various Governments.
12. That it be suggested to the Governments of the various Colonies that they do instruct their several Agents-General in London to obtain all the information possible relating to the outbreak of contagious and infectious disease in various parts of the world and communicate the same to the Colony of New South Wales which shall disseminate the information among the other Colonies.
13. That it is expedient to establish outposts for purposes of quarantine to which vessels approaching Australasian ports with virulent infectious disease on board shall repair before proceeding to their first port of call in Australasia at such points as may be deemed most convenient for the intended purpose.
14. That vessels repairing to such ports and there discharging the sick and such persons as may be considered to have run most risk of infection and having undergone such purification as may be ordered may proceed upon their voyage in Quarantine.

SPECIAL RESOLUTIONS.

AS TO LAWS.

15. That this Conference accepts Part VI. Quarantine of the Public Health Statute 1865 of Victoria as the basis upon which to frame a Federal Quarantine Act.
16. That the said Part of the said Statute should be modified in accordance with the Resolutions in general adopted by this Conference in so far as they touch upon subjects proper to be dealt with in a Quarantine Act of Parliament.
17. That without prejudice to the tenour of the preceding Resolutions the following points be especially mentioned of which it appears to this Conference alteration should be made :—
18. Mails and loose letters should be excepted from the list of articles mentioned in Clause 86 as liable to Quarantine the

same nevertheless to be carefully disinfected before being handed over to the Post Office Officials.

19. All penalties prescribed should be in the amounts at present named but the words "not exceeding" or "not more than" preceding the said penalties should be struck out and the penalties be made absolute in the said amounts.
20. Clause 95 should be so altered that every ship liable to inspection making any Australasian port shall be obliged to hoist the yellow flag therein ordered to be hoisted by ships liable to Quarantine and to keep it flying until the Health Officer shall order it to be hauled down or at night-time the signal lantern therein described and so that the laws applying to ships in Quarantine shall apply to every such incoming ship until the said flag shall have been hauled down by order of the Health Officer the object being to prevent all communication with incoming vessels until the Health Officer shall have satisfied himself that they are not liable to Quarantine.
21. From Clause 101 and elsewhere if they are used in the same sense the words "for the purpose of going ashore" should be omitted.
22. The 9th and 11th Clauses of 17 Victoria No. 29 should be added.
23. That one Quarantine Bill be drawn upon the lines herein indicated and that it be recommended for adoption to the Legislatures of the various Colonies under the title of The Federal Quarantine Act of Australasia.

AS TO THE BILL OF HEALTH.

24. That each vessel should bear but one Bill of Health which should be endorsed at each port of call.
25. That the Bill of Health should be of a prescribed form namely that known as the International Bill of Health.
26. That the fact of any vessel bearing a clean Bill of Health shall not necessarily exempt her from a thorough medical inspection.

AS TO IMMIGRANTS.

27. That Emigrants from Great Britain should be required to present a certificate at the Dépôt in that Kingdom signed by the Medical Officer of Health for the district from which they come declaring the state of the Public Health in that district as to infectious disease and that the Agents-General be instructed to give effect to this Resolution.
28. That if small-pox is epidemic in the district from which any emigrant comes every such emigrant shall be vaccinated or re-vaccinated as the case may be before he shall be allowed to embark.
29. That if any other infectious disease is epidemic in the district from which any emigrant comes all his clothes and effects shall be disinfected before he shall be allowed to embark.

AS TO COMPULSORY VACCINATION.

30. That in the opinion of this Conference the welfare of the whole group of Australasian Colonies demands the enactment of Compulsory Vaccination Laws in each Colony without any delay.

AS TO NOTIFICATION OF INFECTIOUS DISEASES.

31. This Conference earnestly desires that the notification of infectious diseases should be made compulsory in all the Colonies but is of opinion that every useful purpose is served when the Physician is required to inform the Householder in writing of the nature of the disease and when the obligation to notify the existence of the disease to the Authorities is laid upon the Householder alone.

AS TO PARTICULAR DISEASES.

Small-pox.

32. That it shall be the duty of the Surgeon on board any passenger ship destined for Australasia to supply himself with vaccine lymph either human or bovine or both sufficient to vaccinate and re-vaccinate the whole of the passengers and crew.
33. That it shall be the duty of the Surgeon on board any passenger ship in which small-pox occurs during the voyage to vaccinate and re-vaccinate the whole of the passengers and crew on board such ship.
34. That persons arriving in an infected ship not being themselves affected shall be re-vaccinated.
35. That persons able to satisfy the Health Officer that they have been successfully re-vaccinated at a date being not more than six months previous to their arrival in an infected ship may at the discretion of the Health Officer be released after such time as is necessary to cleanse and disinfect their clothing on shore.
36. That those in whom vaccination runs a normal course or who after repeated trials at the Quarantine Ground prove to be insusceptible of vaccination may be released on the fifteenth day.
37. That those who refuse vaccination or re-vaccination shall be detained until the Health Officer is satisfied of their inability to spread small-pox but for no shorter period than twenty-one days.

Cholera.

38. That any vessel having on board any case of cholera whether Asiatic or sporadic or any case which may reasonably be supposed to be cholera in either of these or any other form shall be quarantined.
39. That all hands except such as are actually necessary to cleanse the ship expeditiously and thoroughly shall be landed at the Quarantine Ground at the terminal port where they shall be detained for a period of not less than ten clear days.
40. That at the terminal port in order to facilitate cleansing operations cargo shall be discharged into lighters and may thence be passed out of Quarantine.
41. That cleansing having been completed the hands employed thereat shall be quarantined for the space of ten clear days.
42. That a crew may be supplied to the vessel from the hands first quarantined if the prescribed period has elapsed or otherwise as may be convenient.

Yellow Fever.

43. That any vessel arriving from a country infected with yellow fever shall be required to discharge cargo into lighters and to remain at the Quarantine Ground and in Quarantine until she shall have been cleansed and purified.
44. That her cargo shall be landed at Quarantine wharves and shall there be freely exposed to the air for ten clear days.
45. That the vessel shall be thoroughly cleansed as may be specially ordered in the case of yellow fever.

46. That if no case of yellow fever have occurred on board during the voyage being more than ten days from the date of leaving the infected port her passengers may be admitted to pratique but that if any case have occurred on board the passengers and crew shall be detained for ten clear days on shore at the Quarantine Ground and their effects as long as may be necessary to disinfect them to the satisfaction of the Health Officer.
47. That vessels bearing cases of disease not easily distinguishable from yellow fever shall be subjected to the same treatment as for yellow fever.

Typhus and Relapsing Fevers.

48. The period of detention for typhus and relapsing fever shall be twenty-one days.

Typhoid and Scarlet Fevers, Measles, Diphtheria, &c.

49. That although it is desirable to eradicate typhoid and scarlet fever measles diphtheria and other such diseases from the colonies it has not been shown to the satisfaction of this Conference that any measures of Federal Quarantine that could be adopted would be generally successful. This Conference therefore recommends that the Health Officer of the port for which such passengers are destined shall use his discretion by detaining vessels which bear cases of such diseases for such times as may be necessary, to land the sick and their attendants and to purify and disinfect the part of the vessel used by them the persons landed being detained until he is satisfied of their inability to spread the disease in question.

Leprosy.

50. That in the opinion of this Conference a special examination should be made of all Indian and Chinese immigrants upon their arrival in Australasia in order to ascertain the presence or absence of Leprosy among them.

Rabies.

51. That in view of the danger that rabies will become endemic in Australasia unless measures are taken to obviate it it is advisable that the various Colonies should prohibit the further importation of dogs except they be detained in Quarantine for a period of not less than six months.

AS TO FEDERAL QUARANTINE OUTPORTS.

52. The federal Quarantine outport for vessels approaching Australasia from the Westward should be established at King George's Sound and should be in telegraphic communication with the mainland.
53. The Federal Quarantine outport for vessels approaching Australasia from the Northward should be established at Lizard Island near Cooktown or at any other place which the Government of Queensland may be able to show to be more suitable and should be in telegraphic communication with the mainland.
54. The permanent buildings at each Federal Quarantine outport should consist of hospital accommodation for thirty patients and the buildings necessary for the Medical Officer and the permanent staff. Provision should be made at each Federal Quarantine outport for the temporary accommodation on shore of six hundred persons in order that all persons may be landed when that step is considered necessary in order to effectually cleanse the vessel.
55. A medical officer should be appointed who should receive two hundred pounds per annum as a re-

taining fee in consideration whereof he shall superintend and constantly maintain in efficient working order the permanent staff and buildings of the outport and shall always be ready to proceed to the outport upon receiving notice to prepare to receive infected vessels, and to remain there in charge of the sick and his fees when thus employed should be five guineas per diem in addition to the retaining fee above mentioned.

56. A Superintendent should be appointed who shall be a Storekeeper and a Dispenser at a salary of two hundred pounds per annum with a residence but without rations who shall be responsible to the Medical Officer.
57. Four men preferably retired man-of-war's men should be appointed to fulfil the duties of wardsmen disinfectors labourers and to make themselves generally useful as they may be directed by the Medical Officer or in his absence by the Superintendent at a salary of nine pounds a month each with quarters.
58. There should be a house which shall contain four rooms and a bath-room for the Superintendent to which shall be attached in communication with the former but capable of being shut off from it and having a separate entrance two rooms and a bath-room for the Medical Officer and kitchen and offices.
59. There should be four detached dwellings for the four attendants.
60. There should be a store.
61. There should be erected a sufficient number of wooden platforms to accommodate tents enough to hold six hundred people.
62. There should be a sufficient water supply which shall be raised into overhead tanks by windmills or otherwise as may be most convenient and which shall be thence distributed by pipes throughout the establishment.
63. There should be such laundry accommodation as shall be sufficient to wash the clothes of six hundred persons in thirty-six hours.
64. There should be an efficient disinfecting apparatus.
65. That the expense of the maintenance of the persons landed in Quarantine at the outports should be borne by the owners of the vessels.
66. That this Conference is of opinion that this equipment may be provided for each outport at a cost of about twelve thousand pounds for each outport.
67. That this Conference is of opinion that in order that the federal outports may be constructed in accordance with its intentions and wishes the design of each outport should be entrusted to one of the Delegates who from having taken part in these proceedings is most competent to select the site to plan the establishment and superintend its construction and that in the case of Queensland the Delegate selected shall visit any place which may be recommended by the Government of that Colony as a site for this purpose.

BANQUET TO THE MEMBERS OF THE SANITARY CONFERENCE.

THE delegates attending the Australasian Sanitary Conference were entertained at dinner at the Oxford Hotel, on Thursday night, September 25th, by the medical profession of Sydney, of whom upwards of 50 were present.

Dr. MANNING occupied the chair, and Drs. ROWLING and COX the vice-chairs, the chairman having the delegates sitting on either hand.

At the conclusion of the banquet, which was as well

served as could be expected, the toasts of "The Queen," and "The Governors of the Australasian Colonies" were duly honoured.

Dr. COX proposed "The Parliaments of the Australasian Colonies," and believed that the time was at hand when the medical profession would be much more largely represented in the various Legislatures than at present. He was sure the proceedings of the Sanitary Conference would be largely quoted in Parliamentary discussions, whenever the question of the public health came to be considered, and that all demands made upon Parliament in that direction would be responded to if they were properly put forward. (Cheers.)

Dr. TARRANT, M.L.A., in acknowledging the toast, trusted that the medical profession would soon be better represented than it was in the Legislature, especially in the Upper House, and from the powers of debate the members of the Conference had exhibited at their sittings, it was evident that they, at least, were fitted to shine in the legislative assemblies of the land. (Cheers.) The work of the Conference was a most important one, and he thought the members had shown that the time was come for a compulsory vaccination act. (Loud Cheers.) There was no use hiding the fact that small-pox might be looked upon almost as an endemic disease here; and, as the means existed for stamping it out, or at least mitigating it, the sooner that means was made compulsory the better it would be for the general community. (Cheers.) The Conference was the first step towards the federation of the colonies, and it would always be his pleasure to assist in bringing about what was desirable in that direction, and in forwarding the interests of the profession to which he belonged. (Cheers.)

The Chairman (Dr. MANNING) proposed "The health of the Members of the Australasian Sanitary Conference." (Loud Cheers.) The medical profession, he said, had always stood in the van whenever the question of the prevention of diseases was introduced, and in the large majority of cases it had stood alone in taking steps to achieve that end. Under these circumstances the profession in Sydney felt proud to associate with the members of the Conference, which included such men as Dr. M'Crea, of Victoria, the Nestor of sanitary science in the southern hemisphere—(loud cheers)—Dr. Bancroft, of Queensland, whose name was known wherever scientific research was held in honour—(cheers)—Dr. Paterson, the trusty medical adviser of the South Australian Government—(cheers)—and the able representatives of Tasmania and Western Australia, Dr. Turnley and Dr. Rogers. (Cheers.) Last, but not least, there were the representatives of New South Wales, Dr. Mackellar and Dr. Thompson. (Prolonged Cheers.) They were all proud of Dr. Mackellar, and nothing could have given them a higher opinion of his ability than the way in which he, the originator of the idea of federal quarantine, had conducted himself as chairman of the Conference. (Cheers.) The profession might not agree with some of the details of the work done by the Conference, but all must thoroughly endorse its recommendation for the introduction of a compulsory vaccination act, and he hoped its deliberations would end in the more effectual maintenance and improvement of the general health of the public of Australasia. (Cheers.)

The toast was drunk with enthusiasm.

Dr. MACKELLAR replied on behalf of the members of the Conference, and expressed his sense of the honour conferred on him by his election as president. He regretted that the choice of president had not fallen upon one whose ability was so superior to his own, and whose age rendered him additionally fitted for it. He

referred to Dr. William M'Crea—(cheers)—who had entered the profession before he (the speaker) was born. For many years Dr. M'Crea had been the leader in every movement tending to the advance of sanitary science, and he had shown in every case that amount of determination which entitled him to be classed amongst the "vertebrates." (Laughter.) He hoped that all who had administrative duties would show as much backbone in their discharge of them. ("Hear, hear," and laughter.) The Conference was assembled in common council for the public good, and their aim was to guard a virgin country against the assaults of diseases from which she had hitherto been free. He thanked them for the manner in which the toast had been received.

Dr. M'CREA, in response to calls, also replied, and complimented the medical profession of Sydney upon the high esteem in which they appeared to be held by all classes of society. During the 30 years he had been in Victoria he had never come to Sydney until two months ago, and consequently knew little about the profession here until lately; but now that he knew more of them, especially since the *Australasian Medical Gazette* had been so ably established—(loud cheers)—he was quite convinced of what he had previously remarked. As to what had been said about the profession being more fully represented in the Legislature than it was, he thought its members could better work outside of that sphere of labour, leaving to those who had more leisure to enter upon the field of politics; and with reference to federation, the establishment here of branches of the British Medical Association was the first step towards federal union of all the colonies with the mother country. (Cheers.) He hoped federation would spread between the colonies themselves, and that in the end all the English-speaking people would be joined in a mighty empire, of which the present British empire would be a very small portion, and which would hold such a position as would enable it to govern the world in peace, truth, and equity. (Loud Cheers.)

In response to calls Dr. BANCROFT, Dr. PATERSON, Dr. TURNLEY, and Dr. ROGERS also acknowledged the toast and the kindness with which they had been treated on every hand since they had arrived in Sydney, the last-named expressing his belief that the profession should not flinch from pushing itself into prominence in the political world.

Dr. THOMPSON, the special delegate for New South Wales, was also called, and responded.

Dr. ROWLING proposed "The Ladies," to which Dr. Evans responded, and Dr. M'Culloch proposed "The Press," which was acknowledged by Dr. Creed, the editor of the *Australasian Medical Gazette*, who took occasion to remark, in support of vaccination, that the best proof of the profession's belief in it was shown by the fact that all its members were vaccinated, and their children too. (Cheers.) The people who opposed vaccination generally had no technical knowledge of the matter to assist their judgment, and, he feared, had not the sense to appreciate its benefits. The authorities these people brought forward to support their case were men of no weight, and in the presence of such authorities as Carpenter and Jenner, sank out of sight. (Cheers.) It was desirable for men of high attainments in the profession to represent it in the Legislature; but as regarded the appointment of a Minister of Health, only the most prominent members of the profession should be looked to to supply such an office, and he was afraid they were not those who could spare the time to attend to the duties.

The chairman's health having been drunk, the proceedings terminated.

THE MONTH.

Fiji.

THE Albert gold medal has been conferred upon Dr. W. Macgregor, C.M.G., Receiver-General, and Chief Medical Officer for Fiji, for gallantry displayed by him while travelling in Syria.

NEW SOUTH WALES.

THROUGH the death of the widow of the late J. H. Challis, formerly merchant of Sydney, who died in 1880, leaving nearly the whole of his property to his wife with reversion at her death to the Sydney University, the latter has come in for property valued at £186,000.

DR. AGASSIZ, of Cootamundra, who has been inquiring, on behalf of the Board of Health, into the outbreak of scarlet fever at Barmedman, has reported that on October 1, there were 14 cases there, all mild except one, and that six children have died from the disease.

DR. A. C. BROWNLESS, on his leaving Nymagee, after having practiced there for the last two years, was, on September 15, presented with an address by the leading residents of the district, expressing their very great regret at his departure and assuring him of their deep and sincere affection. The address was accompanied by a gold watch, as a souvenir of the subscribers' respect and esteem. Dr. Brownless has now commenced practice at Wardell, the centre of a sugar-growing and saw-milling district on the Richmond River.

DR. T. D. ATKINS, formerly House Surgeon of the Royal Free Hospital, London, has settled at Condobolin, on the Lachlan River, in a rich agricultural and pastoral district, 310 miles west of Sydney.

MR. JAMES CHILOOT, M.R.C.S., England, 1872, L.S.A., London, 1871, was discovered dead upon his bed at Wardell, in the Richmond River District, on September 11th. A bottle of chloral hydrate was found open in his room.

DR. A. J. HOOD, formerly Resident Medical and Surgical Assistant at the Western Infirmary, Glasgow, has settled at Rocky Mouth, on the Clarence River, in an agricultural district, 323 miles north of Sydney.

DR. LACHLAN HECTOR JOHN MACLEAN, M.D., Heidelberg, M.R.C.S.E., 1852; M.R.C.P., Lond., 1880, formerly House Surgeon at the Charing Cross Hospital, and Resident Medical Officer at the Royal Infirmary for Children, London, and late of the East India Company's medical staff, died at Liverpool, near Sydney, on October 10.

DR. J. H. MACKENZIE, of Temora, has removed to Bega, in a dairy-farming and grazing district, 255 miles S. of Sydney.

DR. M. D. MURPHY, late of Brunswick, near Melbourne, has succeeded to the practice of Dr. Bennett, at Grenfell, an agricultural, pastoral, and gold-field town on Emu Creek, 287 miles west of Sydney.

DR. W. W. J. O'REILLY has returned from his trip to Europe, and re-commenced practice at 3 Hyde Park Terrace, Sydney.

DR. L. D. PARRY, late of Kaitangata (N.Z.), has succeeded to Dr. J. H. Mackenzie's practice at Temora, an important gold-mining township, 288 miles S.W. of Sydney.

DR. G. B. C. PULTNEY, late of New Zealand, has settled at Walbundrie, a township 420 miles south of Sydney.

DR. R. E. RYGATE, late of Grenfell, has removed to Silverton, the centre of an extremely rich mineral district, near the South Australian border, about 800 miles south west of Sydney.

DR. B. B. SCHWARZBACH, Specialist on Diseases of the eye, ear, and throat, has commenced practice in Sydney at 151 Macquarie-street.

DR. J. G. SMITH, late of Grafton, has removed to Lismore, on the Richmond River, the centre of a large agricultural and pastoral district, 357 miles north of Sydney.

DR. M. W. TRAILL, of 211 Macquarie-street, Sydney, has removed to Burwood, where he has commenced practice in conjunction with Dr. Scale; and Dr. C. P. Bellamy, who practiced at Burwood for the last six months, has left this district, and is now taking a holiday.

DR. G. VANZETTI, of Mount Hope, is about to remove to Nymagee, having been appointed Medical Officer to the Nymagee and Hartwood Copper Mines, in the place of Dr. W. H. Rogers, resigned.

DR. FRED. WADHAM, a new arrival from home, has commenced practice at Redmyre, a rising suburb of Sydney.

DR. WILLIAM AUGUSTUS WEST has just returned to the colony from his trip to England, and commenced practice at Derby House, Glebe, near Sydney, in conjunction with his brother Dr. A. A. West.

DR. M. E. WILKINSON, who for the last eighteen months practiced at Pictou, has left the district, and is now practising at Newtown, a suburb of Sydney.

NEW ZEALAND.

DR. CHAS. LOW, of Clinton, has removed to Kaitangata, on a branch of the Molyneux River, in a coal-mining and farming district 60 miles south-west of Dunedin.

DR. BUCKBY, of Te Aroha (prov. Auckland), has removed to Patea (prov. Taranaki), the port of a large district, 100 miles N.W. of Wellington.

DR. W. R. PEARLESS, late of Tarraville, in Gippsland (Vic.), has settled at Waimea (prov. Canterbury), about 16 miles from Hokitika.

QUEENSLAND.

New hospitals are to be erected at Cairns and Maryborough.

DR. W. HARVEY, Medical Officer at the Maytown Hospital, has resigned.

SOUTH AUSTRALIA.

AT a recent meeting of the Adelaide Hospital Board leave of absence was granted to Dr. Stirling, who goes to England, having been appointed by the Council of the University to take part with Dr. Davies Thomas, also of Adelaide, in the selection in England of a professor of anatomy, and to perform other duties in connection with the medical school about to be formed.

AT a recent meeting of the Adelaide Hospital Board, a letter was received from a person styling himself "A Shepherd from Germany," intimating that he, being

skilled in the cure of sprains, dislocations, &c., would give his services to the institution for a small remuneration.

DR. W. GARDNER, of Adelaide, has resigned his position of Surgeon in the S. A. Volunteer Military Force, and Dr. H. E. Astles, Surgeon in the Reserve, has been transferred to the Volunteer Military Force.

DR. M. P. O'LEARY, late of Port Lincoln, has removed to Port Victor, in an agricultural district, 64 miles south of Adelaide.

DR. H. M. SHAND has resigned his appointment as Government Medical Officer at Port Victor, South Australia.

VICTORIA.

MR. BRETT, acting inspector-general of penal establishments, and Dr. Dick, inspector of lunatic asylums, intend conferring upon the question of converting one of the gaols of the colony into an asylum for criminal lunatics, of whom there are upwards of 60 now in confinement, and after they have discussed the matter, they will submit their views upon it to the Chief Secretary.

A DEPUTATION from the Melbourne University, headed by Dr. Moorehouse, chancellor, waited on the Treasurer, on September 24, to ask the Government to take steps to secure medical students at the University the advantages of clinical instruction at the hospital. The Bishop stated that the sub-committee appointed to investigate the character of the clinical instruction to students, had reported that it was not what it should be. The deputation wished the Government to make it an addition to the grant for the hospital, that arrangements should be made to procure practical as well as theoretical instruction in medicine and surgery being given to students. Mr. Service said there appeared to be some misunderstanding between the University and the hospital, and that relations between them were somewhat strained. It was necessary that clinical instruction should be given as effectively as possible. The simplest plan would be to form a committee of representatives of the University and the other bodies interested, to deal with the whole question. If it was then found necessary that they ought to amend the Hospital Act, they would do so, but he did not think the Assembly would agree to the addendum as suggested being made to a grant in aid of the hospital. He would cause a meeting of the bodies interested to be convened, and would appoint a representative of the Government to be present.

NEW arrangements have been made by the Central Board of Health for vaccinating at the Model Farm with calf lymph. Dr. Le Fevre will for the future attend there at 2 o'clock on Wednesdays, and perform the operations. The vaccinations by Dr. Fletcher, at the Manchester Unity Hall, Swanston-street, on Mondays and Fridays, will be continued.

THE Tuberculosis Board have recommended the appointment of a veterinary surgeon to inspect the carcasses of all cattle slaughtered at the various abattoirs for the purpose of determining as to what extent tuberculosis prevails. The Government have adopted the recommendation.

ANOTHER case of leprosy has been reported from Ballarat to the Central Board of Health, who decided to inform the Ballarat East local Board that it was considered inadvisable to forcibly remove the lepers to

Point Nepean as first proposed, owing to their threats to commit suicide if they were removed.

THREE more cases of small-pox were reported in Melbourne on October 2.

MEASLES are very prevalent in various parts of the Sandhurst district.

MEASLES and typhoid fever are prevalent at Eaglehawk. Over 150 cases are reported at No. 123 school, California Gully.

DIPHTHERIA is prevalent in Egerton. Two cases have proved fatal.

DR. BEANEY has been re-elected a member of the Legislative Council.

DR. E. J. LOCK, late of Kingston and Penola (S.A.), and formerly of Beaufort, has settled at Yea, in a pastoral, farming and mining district, 75 miles N.E. of Melbourne.

DR. T. L. M'MILLAN has removed from Collins-street to 97 Toorak road, South Yarra.

DR. J. P. RYAN has returned from Europe, and has resumed practice at 166 Collins-street east, Melbourne.

DR. R. H. SPARROW has removed from Howe Crescent to Kent Villa, St. Vincent place, Albert Park, South Melbourne.

A COMPLIMENTARY Dinner was given to the Hon. Dr. Beaney in the Melbourne Town Hall, on October 8, to commemorate his re-election to the Legislative Council.

DR. F. A. BENNET, just arrived from Scotland, has settled at Bairnsdale, in North Gippsland, 185 miles E. of Melbourne.

DR. H. C. BOWSER, has settled at Footscray, an industrial suburb 4 miles W. of Melbourne.

DR. W. H. COUTIE has been appointed to take charge of the Cutpawpaw Sanatorium, near Williamstown, in the place of Dr. Mailer, who has resigned.

DR. C. H. DEGNER, formerly of Cobar (N.S.W.), has settled at Natimuk, a post town 228 miles N.W. of Melbourne.

DR. H. M. FENWICK, a new arrival from home, has purchased Dr. Hora's practice at Carlton, a suburb adjoining Melbourne.

DR. H. C. JEE, late of Thursday Island, has commenced practice at Mount Wycheproof, a post town 200 miles N.W. of Melbourne.

DR. J. A. KENNISON has removed from Toorak-road to Chapel-street, South Yarra.

DR. JOHN MARCHEBANK has succeeded to Dr. Jack's practice at Terang, in a pastoral district 134 miles S.W. of Melbourne.

DR. W. J. MOUNTAIN, late of Clarence Town (N.S.W.), has settled at Lillimur North, a post town 321 miles N.W. of Melbourne.

DR. R. TALBOT, Surgeon-Major in the Victorian Militia Force, has been placed on the retired list, with permission to wear the prescribed uniform.

MARRIAGE.—Hacon-Campbell—On September 1st, at St. Paul's Cathedral, Wellington, by the Venerable Archdeacon Thorpe, Walter Edward Hacon, Medical Superintendent Hospital for Insane, Sunnyside, Christchurch, N.Z., to Margaret Jane, eldest daughter of A. Le Grand Campbell, of Wellington, N.Z.

MEDICAL APPOINTMENTS.

Anderson, James Fisher, L.R.C.P. *et* R.C.S., Edin., to be Government Medical Officer and Public Vaccinator for Urana, N.S.W.

Ashe, William Conyngham, L.R.C.S., Irel., to be additional Vaccinator at Newcastle, N.S.W.

Atkins, Thomas Dealtry, L.R.C.P., Edin., M.R.C.S., England, to be additional Vaccinator at Condobolin, N.S.W.

Barker, Edward Hamilton Blair, M.B., Melb., to be Public Vaccinator for Robe, S.A.

Beeston, Joseph Lieveley, L.K.Q.C.P., Irel., L.R.C.S., Irel., to be additional Vaccinator at Newcastle, N.S.W.

Brett, John, M.R.C.S.E., L.R.C.P., Edin., to be Public Vaccinator at the Calf Lymph Depot, Royal Park, Melbourne.

Buckby, Arthur Grey Hesbrige, L.F.P.S., Glasg., to be Public Vaccinator for the Patea and Waverley districts, N.Z.

Calder, Robert, M.B. *et* Ch. M., Aberd., to be Government Medical Officer and Vaccinator for the district of Brisbane Water, N.S.W.

Coughtrey, Millen, M.B. *et* Ch. M., Edin., to be an additional Public Vaccinator for the Dunedin district, N.Z.

Davidson, Lewis Gordon, M.D. *et* Ch. M., Aberd., to be additional Vaccinator at Sydney, N.S.W.

Degner, Charles Henry, M.D., to be Public Vaccinator at Natimuk, Vic.

Eadie, James, M.B. *et* Ch. B., Melb., 1883, to be Public Vaccinator for Sandhurst, Vic.

Foord-Clark, Harry, L.R.C.P. *et* R.C.S., Edin., to be additional Vaccinator at Moree, N.S.W.

Gillon, George Gore, M.B. *et* Ch. M., Glasg., to be a member of the Honorary Medical Staff of the Wellington Hospital, N.Z.

Haughton, Thomas Wilfred, M.B. *et* Ch.B., Dub., to be Public Vaccinator at Tamworth, N.S.W.

Herdegen, Moritz, M.D., to be Health Officer for Lowan Shire, Vic.

Hodson, Francis Octavius, L.K.Q.C.P., Irel., to be Assistant Surgeon of the hospital for Pacific Islanders, Mackay, Queensland.

Hoots, Alton Kingsley, M.R.C.S.E., to be Government Medical Officer and Vaccinator for the District of Yass, N.S.W.

Hood, Alexander Jarvie, M.B. *et* Ch. M., Glasg., to be additional Vaccinator at Rocky Mouth, N.S.W.

Inglis, James, L. *et* L.M.D.R.C.S. *et* R.C.P., Edin., to be additional Vaccinator at Newcastle, N.S.W.

Jee, Henry Christian, M.R.C.S.E., L.R.C.P., Edin., to be Health Officer for St. Arnaud shire, East riding, Vic.

Kealy, Joseph Patrick, L.R.C.S.I., L.K.Q.C.P., appointed Medical Officer, Hillston Hospital, N.S.W., also Government Medical Officer and Public Vaccinator at Hillston, N.S.W.

Kendall, Theodore Mallier, L.R.C.P. *et* R.C.S., Edin., to be additional Vaccinator at Sydney, N.S.W.

Le Fevre, George, M.D. *et* Ch. M., Edin., to be Public Vaccinator at the Calf Lymph Depot, Royal Park, Melbourne.

Look, Ezekiel John, L.S.A., Lond., to be Public Vaccinator and Health Officer at Yea, Vic.

Low, Charles, M.B. *et* Ch. M., Edin., to be Public Vaccinator for the Kaitangata District, N.Z.

M'Donnell, Edward Patrick, L.K.Q.C.P., Irel., L.R.C.S., Irel., to be additional Vaccinator at Forbes, N.S.W.

Mackenzie, John Hugh, L. *et* F.R.C.S., Edin., to be Government Medical Officer and Vaccinator for the district of Temora, N.S.W.

Maller, Melrose, M.B., Melb., appointed Resident Medical Officer at the Melbourne Hospital.

Mason, Harry Wharton, M.B. *et* Ch.M., Edin., to be Government Medical Officer and Public Vaccinator at Tumut, N.S.W.

Mountain, William John, M.R.C.S.E., to be Public Vaccinator at Lillimur North, Vic.

Murphy, Michael Dominic, L.F.P.S., Glasg., elected Medical Officer to the Grenfell Hospital, N.S.W.

O'Leary, Morgan Philip, L.K.Q.C.P., Irel., M.R.C.S.E., to be Government Medical Officer at Port Victor, S.A.

Parry, Lloyd Davenport, L.R.C.S., Edin., appointed Medical Officer to the Temora Hospital, N.S.W.

Pearless, Walter Reif, M.R.C.S.E., to be an additional Public Vaccinator for the Waimies South district (Prov. Canterbury), N.Z.

Phillips, George Henry, L.R.C.P., Edin., M.R.C.S., Eng., to be additional Vaccinator at Parramatta, N.S.W.

Pollen, Henry, M.B. *et* Ch. M., Dub., L.K.Q.C.P., Irel., to be Government Health Officer for the Port of Gisborne, N.Z.

Porter, Charles Frederick, M.R.C.S.E., L.R.C.P., Irel., to be Public Vaccinator for Flinders and Kangaroo, Vic.

Powell, A. Worsley, L.R.C.P. *et* R.C.S., Edin., to be Assistant Colonial Surgeon and Medical Officer, Mount Gambier Hospital, S.A.

Protheroe, John, L.R.C.P., Edin., M.R.C.S., Eng., to be additional Vaccinator at Richmond, N.S.W.

Pultney, George Brown Crookston, M.B. *et* Ch. M., Glasg., to be Public Vaccinator for the District of Walbundrie, N.S.W.

Ray, Henry, M.D., M.B., Ch. M., Glasg., L.R.C.P. *et* R.C.S., Edin., to be additional Vaccinator for Goulburn, N.S.W.

Reid, George Moore, M.D., Ed., L.R.C.P., Lond., M.R.C.S.E., to be a Surgeon in the Victorian Military Force, with the relative rank of Captain.

Rowling, Charles Edward, M.R.C.S., Eng., L.R.C.P., Edin., to be Public Vaccinator for the District of Parramatta, N.S.W.

Scott, William George, M.R.C.S.E., to be Health Officer for the Port of Manukau, N.Z.

Smith, John, L.F.P.S., Glasg., to be additional Public Vaccinator for the Carterton District, N.Z.

Smith, John Govett, M.R.C.S., Eng., to be additional Vaccinator at Lismore, N.S.W.

Smith, John Walker, L.R.C.P., Edin., to be Health Officer for shire of Ballan, Vic.

Stapleton, Joseph John, M.B. *et* Ch. M., Edin., M.R.C.S., Eng., to be additional Vaccinator at Armidale, N.S.W.

Vansetti, Giulio, M.D., to be Public Vaccinator for Mount Hope, N.S.W.

Whitton, James, M.D., L.R.C.S., Edin., to be Public Vaccinator for the Hamilton district, N.Z.

Williams, William Daniel Campbell, L.R.C.P., Lond., M.R.C.S., Eng., to be additional Vaccinator at Sydney, N.S.W.

Woods, William Cleaver, M.B. *et* Ch. M., Edin., to be additional Vaccinator at Albury, N.S.W.

Wright, J. C., M.B., Melb., appointed Resident Medical Officer at the Melbourne Hospital.

PUBLICATIONS RECEIVED.

Diseases of the Heart and Thoracic Aorta. By Byrom Bramwell, M.D., F.R.C.P.E., Lecturer on the Principles and Practice of Medicine, and on Practical Medicine and Medical Diagnosis, in the Extra-Academical School of Medicine, Edinburgh, &c., &c., with 317 Illustrations. Edinburgh: Young F. Pentland, 1884.

Dr. B. W. Richardson's Asclepiad, Vol. 1, No. 3. London: Eade and Caulfield.

Gunshot Wounds of the Small Intestines. By Charles T. Parkes, M.D., Professor of Anatomy in Rush Medical College, Chicago, Ill., U.S.A. Chicago: Cowdrey, Clark and Co., 1884.

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CORRESPONDENCE.

A VERY AMATEUR HOMŒOPATH.

To the Editor of the A.M.G.

SIR,—I regret you should have been so much in need of a subject for your periodical lately, as to be under the necessity of alighting on such an humble individual as myself; though right here, I will acknowledge that I only hold you responsible in the matter of publication, as I am convinced from internal and external evidence, as far as the article itself was concerned, that it was either written or inspired by a certain individual residing in this locality; one who has not thought it beneath his dignity to revile and backbite me, from house to house, till one of his friends cried shame upon him. Still, sir, I do certainly think you ought not to have allowed any person the use of your columns, for the purpose of making an uncalled for attack, and in the most ungentlemanly and undignified manner, upon another. Of myself, personally, you could know little or nothing, and must therefore have been furnished with information by one, who yet lacked the moral courage to append his name to his production, preferring, coward-like, to stab from behind a shield. And wherein lies the head and front of my offending? apparently in the fact, that I had, and have been, doing what Doctors Murino, Petros, and others had recommended, viz., treating and curing cases of typhoid fever by means of tincture of Proto-sulphide of Mercury, which, according to the dicta of this luminary, is impossible inasmuch as the Proto-sulphide being insoluble, a tincture cannot be made of it. It is of course proverbially true that doctors differ. Herewith, I send you a phial of tincture of the Proto-sulphide of Mercury 6x, prepared and procured at Messrs. Fisher and Co.'s Pharmacy, a house of well-known respectability, where any attenuation, either *trituration*, or *dilution*, required can be obtained.

In addition, I would ask you as a professed lover of truth, and one open to conviction, to refer to Dr. Hales' great work, on the "New Remedies" vol. 1st, page 538, fourth edition, 1879, a work not only of American, but also of European fame, and you will find that he mentions as official preparations, of the Proto-sulphide of Mercury, triturations up to the 6x and *dilutions*. It will now I think, be evident to every candid mind not warped by prejudice, that my opponent who tried to write me down, was not so well acquainted with the properties of Ethiops mineral, as he would make your readers believe. As I trust, sir, you will now be convinced that you have treated me unjustly in allowing your columns to be the vehicle of holding me up to contempt, you will see it your duty as an honourable man, as I believe you to be, to allow this rejoinder in self-defence to appear in your next issue; and, with the view of antidoting the venom of the attack, forward copies of it hither and elsewhere, to those persons to whom copies of the former issue were to my certain knowledge gratuitously sent, as of course you are aware. I have now been practising Homœopathy, *pro bono publico*, for ten years, assuming no titles and charging no fees, and I thank God, that although a very large number of sick people both here and in various other parts of the colony have passed through my hands, I have been the instrument in saving many lives and relieving much suffering, and I purpose continuing to do so as long as the people have confidence in me, and can, therefore, afford to smile at the petty attempts made to injure me. I will just refer to one very interesting case of cure, which, indeed, any man might be proud of. It was that of a duly qualified and

registered physician and surgeon, who had suffered all his life from Chorea, and had taken any amount of medicine prescribed by himself and his Allopathic brethren, without deriving any benefit; but after a fair trial of one or two homœopathic remedies, he soon regained health, to which he had been for years a stranger, and as an expression of his grateful feelings, presented me with a silver snuff box before he left the district.

I am sir, Yours, &c.,

EDWARD HOLLAND.

Dubbo, October 3rd, 1884.

[We publish our correspondent's letter with a great deal of pleasure, feeling that we are not justified in withholding from our numerous readers any little incident which will give them an opportunity for a laugh, to lighten the wearisome routine of life. We think he is unnecessarily modest when he speaks of himself as "an humble individual," being of opinion that a man who, without dissection, without teachers, without opportunity for clinical instruction, and who upon the knowledge obtained by mere desultory reading during the intervals occurring in the course of his clerical work, which we presume he does not neglect, is not only able but willing to reform the present system of medicine and teach men who, having spent some years of their lives solely in the study of all the subjects necessary, have obtained their diplomas as medical practitioners, is no ordinary man but a genius, who must have been wasted in the various bush townships where he has buried himself, evidently to the loss of the rest of the world. It is unfortunate, however, that we must accept, in preference to our correspondent's assertion, the ordinary chemical law, *that a substance which is insoluble is incapable of solution*, and therefore that though he sends us a bottle, labelled "Mercurius Proto-sulph. 6x," its sole connection with proto-sulphide of mercury is this label. Its solubility however, is hardly worth discussing, as the fluid, according to the homœopathic formula, professes to contain but one in ten hundred thousand million parts. We think it well for the sick people whom he doctors that he is content to use remedies of so feeble a description as this, and sincerely recommend him to continue to do so, and not, as he values his peace of mind, to use any more potent, when perhaps, except so far as delaying the adoption of adequate treatment by a properly educated man, he will do no harm. One phrase which he uses is a slight puzzle to us as to the meaning which he intends to convey by it—"that *although* a very large number of sick people, both here and in various other parts of the colony, have passed through my hands, I have been the instrument in saving many lives and relieving much suffering." Does he mean to say that, *in spite* of their passing through his hands, they did not suffer and they did not die? As to the last paragraph of his letter, we regret that, without an accurate clinical report, we cannot accept the very successful repair of the dilapidated "duly qualified and registered physician and surgeon" as a triumph of homœopathy, except perhaps so far as it depended on a change from the patient's usual quantity of whisky to strictly infinitesimal doses of, say, the 6x dilution, even though the case were authenticated by a sight of the "silver snuff-box," which at present we have to take upon trust.—ED. A.M.G.]

MEDICAL ETIQUETTE.

(To the Editor of the A.M.G.)

SIR,—I should feel much obliged if you would publish the following cases in your journal, asking for comment from the profession generally as to etiquette, &c. :—

Case 1. I was called to see a patient in the country, and went accordingly, gave a serious prognosis, and asked to be informed how case progressed. A few weeks later I was asked if I had any objection to meet Dr. P—— in consultation. I immediately agreed, and when I met him at the house he informed me that he had been originally called, had refused to go, and referred messenger to me, as my predecessor had been patient's family attendant. Notwithstanding this he visited patient twice after my first visit without communicating with me, and knowing that I was in attendance. After consultation he held that the case was his.

Case 2. This case is even worse than the first—

A boy had his toe severely crushed in a cog-wheel in a brickworks yard. I was called in and thought it possible to save the toe. The weather was cold at the time. I tried to save it and failed, owing, probably, to some very hot days which succeeded. Having decided to amputate, I called in Dr. W——, who kindly administered anæsthetic for me, and removed the toe by one of the ordinary operations. The succeeding few days were still hot. The foot became oedematous and red as far as the ankle and very painful; also slightly dusky near the wound. I told the friends that possibly next morning the question of higher amputation might have to be considered, and adopted local depletory measures, with elevation of foot. In the evening the foot was much better, and next morning I informed the friends that the question of further amputation would not have to be considered. I saw the patient during that day and the next morning, when all was going well. On the evening of which day I was informed that Dr. P—— had been sent for and had carried the patient off in triumph, in his "buggy," to the T——h Hospital, and admitted him there under his own care.

It may be stated that Dr. P—— had no right to admit patients to the hospital during the current quarter, except with my sanction. We had mutually arranged, with the knowledge of the Hospital Committee, to work the hospital gratuitously, taking alternate quarters on duty. I am on duty until the end of September. Hearing that patients had been admitted to the hospital, I went down there at 9 p.m., and found that Dr. P—— had admitted my patient, whom I operated on a few days before, and another person; both to go under his own treatment.

The boy was admitted to the hospital by him on Friday, 5th September. I understand he visited him on the 6th September, but on the 7th, 8th and 9th inst. he did not see him. It was reported he had gone to Sydney. I did not receive any communication from him whatever in relation to the hospital.

T. W. H.

INHALATION OF ETHER IN SNAKEBITE.

To the Editor of The A. Medical Gazette.

SIR,—I regret my inability to supply more particulars worth recording of the case of snakebite treated by inhalations of ether.

I believe ether will prove of much value in such cases, with less danger to the patient than the intra-venous injection of solution of ammonia. Two cases of ammonia injection I have seen, the first lost the biceps tendon and much of the structure over the front of the elbow joint, the use of the arm being well-nigh lost, the second patient lay for a long time with extensive sloughing of the skin over the foot. Though both were treated by medical men, I consider the ammonia was not injected into the veins but into the cellular tissue. Indeed it would be difficult for any one but an expert surgeon to inject ammonia into a vein with the ordinary sharp-pointed subcutaneous needle.

Ether could be administered to a patient by any person and little harm could come of the treatment except the liquid were ignited. Some general directions would need to be given, and your paper could easily supply them.

JOS. BANCROFT, M.D.

Brisbane, September 10th, 1884.

AMERICAN DIPLOMAS AND THE N.S.W. MEDICAL BOARD.

(To the Editor of the A.M.G.)

SIR,—Will you kindly give space in your columns for the insertion of the following lines :—Yesterday, the 8th ult., I presented a diploma for the degree of Doctor of Medicine, granted by the University of Philadelphia, U.S. (this University being one whose degrees are recognised and well thought of in that country), for registration to the Medical Board of N.S.W. They refused to register it, alleging, as the reason for their declining to do so, that a course of study extending over three years, in a recognised medical school, was a necessary qualification. That necessity, in one sense, I have not complied with, but the course of study I did undergo was thought sufficient by the examining board at Philadelphia to allow of my becoming a candidate for the degree; and I was actually for something over two years and a half keeping my terms and attending the University schools. I was also for upwards of twelve months a pupil of one of the first surgeons of the day, viz., Prescott Hewett, Esq., of London, and for the same period assistant-surgeon in the American navy, and six months of the latter mentioned time was passed in the medical school specially set apart for the study of gunshot and other wounds—a school almost exactly similar to Netley in England. I was also for five months before going to America at Guy's Hospital, altogether making a total of upwards of five years' medical and surgical education. And yet the board rejects me on the ground of this not being sufficient. Is not this rather hard? I think so. A man devotes all his early years to the study of a profession, and because—for family reasons of a pecuniary nature—he is not able to qualify in England, he is refused registration. Does the Medical Board recognise what it is doing by this refusal? It is keeping me from earning a living for myself and family in the way in which, of all others, I am best qualified to earn it. I was offered a lucrative position in this colony, my diploma and

testimonials were considered all that was necessary, and the only thing that was asked was that I should register. This I endeavoured to do, with the result before mentioned, and as a natural consequence, I shall lose the appointment. I lost the diploma in Melbourne, and was at the expense of upwards of £50 to regain it. And now by their act the board have made it almost worthless. I again ask is not this hard? I know full well that American diplomas are deservedly unpopular, because so many of them are obtained almost without study. But this was not my case. I studied hard, and while studying had to work hard in other ways to earn my own living, and after all this of what avail is it? Should any of the Medical Board read this letter, written with all respect to them, I hope it may perhaps induce them to reconsider their determination. I may mention that in addition to the M.D. degree I also received a license from the School of Medicine of New York, which license was unfortunately lost at the same time as the diploma, and which I have not been able to regain.

I am, &c.,

V. E. HERBERT, M.D.

Picton, October 9, 1884.

[We are of opinion that the Medical Board had no choice in the matter, but, as required by their regulation fixing the shortest time for study at three years, were obliged to refuse compliance with our correspondent's application for registration. We sympathise with him to this extent, that no doubt many less qualified men, who have studied for a less time than he have been registered as medical practitioners in New South Wales, but it was in consequence of their having made false declarations, which the Medical Board have often accepted with a blind confidence in human nature which is anything but satisfactory to well wishers of the public weal. We, ourselves, think even three years too short, and would make the minimum four years as required to obtain diplomas in the United Kingdom. We again reiterate our approval, as expressed in last number, of the action of the Queensland Medical Board in refusing to register any American diploma until its possessor had been examined at either the Sydney or Melbourne University.—ED. A. M. G.]

REPORTED MORTALITY FOR THE MONTH OF AUGUST, 1884.

Cities and Districts.	Population.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from							
				Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Child-bearing.
N. S. WALES.											
Sydney	103,379	177	59	...	2	...	8	1	4	20	5
Suburbs	120,832	214	96	...	5	4	7	3	6	19	4
NEW ZEALAND.											
Auckland	27,774	50	20	...	...	5	8	...	...	5	...
Christchurch	16,260	19	8	...	...	...	...	...	...	...	...
Dunedin	26,032	21	5	...	...	1	...	...	...	2	1
Wellington	22,547	37	13	...	...	2	1	1	1	1	...
QUEENSLAND.											
Brisbane	26,557	27	13	*	...	...	...	...	...	...	...
Suburbs	9,612	26	12	...	...	...	...	...	...	...	...
SOUTH AUSTRALIA.											
Adelaide	315,337	385	166	10	3	11	...	3	4	37	2
	42,605	75	21	...	...	...	...	...	...	13	1
TASMANIA.											
Hobart	28,270	44	11	...	...	1	...	2	...	3	...
Launceston	17,819	23	8	...	...	2	...	...	...	2	...
Hospitals, Asylums, Gaols, &c. .	1,232	35	...	...	...	...	...	...	...	...	...
Country Districts	80,557	73	...	...	...	2	1	1	3	...	...
VICTORIA.											
Melbourne	65,791	93	230	22	...	10	37	13	4	80	6
Suburbs	238,618	498									

* The Official Monthly Report on the Vital Statistics of Brisbane and Suburbs does not show the number of deaths from the various diseases.
† The population of N. S. Wales, Queensland, and Adelaide is that of the census of 1881; New Zealand, South Australia, Tasmania and Victoria show the estimated population at the present date.

Gold Medal, Calcutta Exhibition, 1884.

'VICTORIA' OFNER BITTER-WATER.

The Best and Strongest Natural Aperient.

A Natural Fluid Magnesia.

AS A SAFE, ORDINARY, AND GENTLE APERIENT.
IN INFLAMMATION AND CONGESTION.
IN RHEUMATIC AND GOUTY DISORDERS.
AGAINST UNDUE TENDENCY TO FAT.
AGAINST HÆMORRHOIDS.
IN BILIOUS ATTACKS AND DISORDERS OF THE LIVER.

Nature's Aperient Remedy.

DURING PREGNANCY, AND IN MANY FEMALE DISEASES.
FOR HABITUAL CONSTIPATION.
IN ORGANIC DISEASES RESULTING FROM FATTY DEGENERATION.
TO REMOVE THE CONSEQUENCES RESULTING FROM EXCESS IN DIET, ETC.

One Wineglassful will usually relieve the most Distressing Headache.

THE following comparative analysis of the undermentioned Hungarian Bitter-Water Springs shows the "VICTORIA" to be unquestionably superior to all others, and the strongest aperient water known, although its action is gentle and speedy.

The active ingredients of the Sulphate of Sodium and Sulphate of Magnesia, no other waters can be compared with "VICTORIA," which contains 50 to 58 per cent. of these solids.

Analysis of PROF. H. E. ROSCOE, F.R.S., Owens College, Manchester, of Victoria Water.

	VICTORIA.	Hunyadi Janos.	Esculap.	Friedrichshall.
Sulphate Magnesium	3281·07	1563·50	1750·3	641·38
„ Sodium	1716·93	1579·57	1340·7	715·35
TOTAL	4998·00	3143·07	3090·10	1356·73

ONE BOTTLE OF "VICTORIA" IS EQUAL IN ITS EFFECTS TO TWO OF OTHER BITTER-WATERS, HENCE IT IS MUCH CHEAPER.

PROFESSOR BALLO, Official Chemist to the Ofner district, says :—

"The water of this spring, containing 58·156 grains of total soluble constituents in 1,000 parts of the water, represents itself as the most concentrated and most efficacious mineral water of that kind. The proportion of the two chief constituents of the Sulphate of Magnesia and Sulphate of Soda, as found in the water of the "Victoria Spring," is a peculiarity which distinguishes it from *all the other waters* of that kind, even from the same locality."

In cases of indigestion, stomach, and liver affections, constipation, and other derangements of the system, as a family medicine this has no equal.

O. WIDMAN, M.D., says :—

"Victoria Water is highly efficacious, produces no uneasiness, and even a small dose of it will act more rapidly than any other water of the kind."

DR. S. LOW, in a paper read before a Congress of Ofner Physicians, remarks :—

"At the head stands 'Victoria' Bitter-Water ; by reason of its richness in Sulphate of Magnesia, it surpasses all other Bitter Mineral Waters."

For ordinary aperient purposes, a half wineglassful may be taken at bed-time, or a wineglassful taken in the morning fasting. It is most efficacious when warmed to a temperature not below 60°, or when an equal quantity of hot water is added to it.

SOLD IN BOTTLES AT 1s. 6d. and 2s.

And may be obtained of any Chemist or Patent Medicine Vendor in the United Kingdom and the Colonies.

The "VICTORIA" NATURAL BITTERWASSER of Budapest, Hungary.

WHOLESALE DEPOT FOR ENGLAND AND COLONIES—

24 & 25 HART STREET, BLOOMSBURY, LONDON, W.C.

AUSTRALASIAN MEDICAL GAZETTE.

CLINICAL LECTURE ON ANEURISM OF THE INNOMINATE ARTERY.

DELIVERED AT THE MELBOURNE HOSPITAL

BY THE HONORABLE JAMES GEORGE BEANEY,
M.P., M.D., F.R.C.S.E., L.K.Q.C.P.I.,
M.R.I.A., HON. SURGEON TO THE HOSPITAL.

(Continued from page 5.)

The next case is interesting, but it differs from the preceding one in some of its most important features. I will read the notes of the case.

CASE II.—*Aneurism of the innominate artery ; pain and difficulty of breathing when lying down. Consecutive deligation of the carotid and subclavian arteries. Recovery.**

J. R. M.—, aged thirty-two, a veterinary surgeon, married, was admitted into Hospital on the 8th March, 1884, suffering from a pulsating tumour in the neck.

HISTORY.—He states that he has noticed for some months past a small swelling in the episternal notch, which extended outwards towards the right side, beneath the clavicle. He has, however, observed for the last two years some difficulty in swallowing, and trouble in breathing, exaggerated when lying down, and relieved on standing up, the breathing being also relieved on taking a gulp of cold water. Occasionally the breathing has been very bad. He has suffered from palpitation, and this with the dyspnoea has been increased on exertion.

For the last nine months he has had troublesome pains in the right shoulder, occasionally shooting to the left. These have prevented him from using his arm. The pains extend occasionally up to the occiput, and down the right arm. He has never had any of the symptoms of syphilis. He has suffered from rheumatism, and states

that about once a year his great toe becomes painful, swollen, and glossy looking. About eight years ago, suffered from small abscesses below the lobe of the right ear, and over episternal notch. His father suffered from gout, and his mother from asthma. About four years ago he says he was on his way home through a lonely part of one of the suburbs, when he was set upon by three men and garrotted.

ON ADMISSION, he is a muscular, light-complexioned man, 5 feet 7 inches in height, weight 11 stone, and to all appearances healthy. He complains of dysphagia and dyspnoea ; worse when lying on his back, and relieved on standing up. He has pains of a darting character in the right shoulder, back of his head, right elbow, and forearm.

PHYSICAL EXAMINATION.—There is a dilatation of the veins and venous capillaries on the right side of his chest ; small cicatrices are seen on the episternal notch and below the right ear (the result of the abscesses previously noted). The chest expands readily, and equally on both sides. The sternal end of the clavicle is displaced upwards and forwards, and rises and falls with the pulsation of the tumour. This tumour bulges, and extends to about half an inch to the right of the right sterno-clavicular articulation, nearly to the opposite (left) joint, being about two inches in length. It extends above the displaced clavicle about an inch. It pulsates laterally and at the apex, and separates two fingers when placed upon it. The veins over the tumour are dilated. On percussion there is dulness and a sense of resistance over the upper sternum, and about an inch from the right sternal line, extending downwards to the lower border of the second rib. On auscultation the heart's apex beat is found displaced somewhat to the left, being about its normal distance below the nipple, but half an inch to the left side. At the apex the first and second sounds are distinct, and no bruit is heard. At the base there is a bruit, rather muffled, heard with the first sound, and the second sound is markedly accentuated. Over the tumour a distinct murmur is heard. Posteriorly no bruit can be discovered. There is a marked difference in the radial pulses, the right being much stronger. There is no difference perceptible in the two temporals. Pupillary area of both eyes equal. Pressure on the tumour causes some difficulty of swallowing, and a slight cough.

A consultation of the surgical staff was held on the case, when it was decided to give the patient

* Reported by J. W. Florence, M.B., Ch.B., House Surgeon.

the chance of prolonging his life by the distal operation, tying first the carotid artery; and, if found necessary, to apply a ligature to the subclavian in the third part of its course. He was then allowed to leave the Hospital for a short time to consult with his friends as to the propriety of submitting to an operation which might probably be attended with fatal consequences.

CAROTID OPERATION.—Having made up his mind to undergo it, he was brought into the operating room on the 4th of April, and placed under the influence of chloroform, the head with the chin being turned towards the opposite side. An incision two inches in length was made in the anterior oblique border of the sterno-mastoid muscle, opposite the larynx, dividing the platysma, superficial fascial and cervical nerve, keeping clear of the externa, jugular vein. The muscular fibres of the sterno-mastoid were readily exposed, and this muscle, together with the omo-hyoid, was held apart by retractors, and the fibrous sheath of the artery exposed, with the artery pulsating feebly within. At this stage of the operation some smart bleeding was encountered, which was speedily arrested. The sheath was opened, and the needle passed from without inwards. It was then armed with prepared kangaroo tendon and withdrawn, and the ligature tightly applied. The wound was irrigated with a 5 per cent. solution of carbolic acid, carefully dried, and the edges brought together by silver-wire sutures, over which a layer of absorbent wool and styptic colloid was applied. It was noted that during the operation there was no difference in the size of the pupils. Towards the latter part of the operation the face became very congested. Immediately after the operation he was given a quarter of a grain of morphia hypodermically, and was carried to his bed. Hot bottles were applied to his feet and the calves of his legs. He was placed in a special ward, with strict orders that he be kept as quiet as possible.

At nine p.m. when visited there was no appreciable difference in the size of the pupils; both responded to light, and were normal. There was no difference in temperature between the two sides of the head; pulsation in the temporal of the right side absent; no headache; had slight pain about the wound in swallowing; temperature, 99° F.; complains of being thirsty; ordered iced milk.

5th, a.m.: Has no pain in the head; pupils equal, act to light, and normal. No pulsation in the temporal. Did not sleep well during the night; would doze a little, and then wake up. The tumour seems much the same. Five p.m.: Has retention of urine, which was drawn off. Says he feels well; breathing easy; difference in the

pulses still marked; slight pain in the forehead; pupils normal. In the evening the catheter was again used. 6th: Still pain in the forehead; water again drawn off; bowels not open since the operation, and he was ordered an aperient. On the 7th the wound was dressed for the first time, and looking well; painted again with styptic colloid. 11th: Temperature has been up the last two or three days; has headache, and breathing rather troublesome. 23rd: The patient made an uninterrupted recovery, the wound having healed by the first intention. On the 24th the following notes were made:—The clavicle is not so prominent, and the tumour in the episternal notch seems firmer. The pulsation of tumour apparently less; the murmur is still distinct. The pupils are equal, but there is still the marked difference in the radial pulses. On pressing on the tumour he complains of pain in the left shoulder. He complains of difficulty of breathing at night; relieved by sitting up; also of a whistling sound in breathing in the same posture. He especially observes the difficulty and whistling sound when eating, but these are relieved on taking a gulp of water. He complains of a feeling of pressure over the left side of the chest. It was decided to tie the subclavian.

SUBCLAVIAN OPERATION.—On the 28th April I proceeded to tie the right subclavian artery in the third part of its course as follows:—Chloroform having been administered, the patient's head turned to the opposite side, and the shoulder well drawn down by an assistant, I drew the skin of the neck down over the chest, and made an incision on to the clavicle for about its middle third. The deep fascia was then divided on a director. With the point of the director, the cellular tissue of the subclavian triangle was scratched through, and the scalenus anticus muscle exposed. At this stage of the operation some large veins that were cut required ligature. The artery was found, pulsating very feebly behind the scalene tubercle, and the aneurism needle passed around the artery from above downwards. A prepared kangaroo tendon was passed through the eye of the needle, the latter was withdrawn, and the ligature tied tightly. The wound was irrigated with a 2 in 40 solution of carbolic acid, its edges stitched with silver and horse-hair sutures, and styptic colloid with cotton wool applied. The arm was covered with cotton wool, and bandaged with a flannel roller; to be kept raised on pillows. Hot bottles to be applied to the feet, arms, and body.

29th: Through the night the breathing was troublesome and laryngeal in character. Has slight inclination to cough. He complains of tingling in the fingers and thumb, being worse in the latter. He has some difficulty in swallowing.

29th, p.m. : Complains of a feeling of pins and needles in the finger-tips. Breathing much easier than it was this morning. To have a draught composed of chloral and bromide of soda. 30th : Slept about six hours last night. His breathing much better this morning. Complains of shooting pains over the right shoulder down to the fingers. The right hand is warm and perspiring. May 2nd : Dressed for the first time to-day. Wound looking well. Temperature of both extremities the same—100° F. 3rd : Same ; bowels constipated ; ordered a laxative. 6th : Dressed this morning under the spray. There is some swelling, induration, and redness about the edges of the wound. Free discharge of healthy pus. Complains of pain in the shoulder. All sutures removed, and ordered to lie on the right side to allow of free drainage. 9th : Wound looking well ; discharge less.

He states that he has now no difficulty when swallowing, and only occasionally has troublesome breathing. When he lies on his back the breathing is heard to be slightly laryngeal, but not so much as before the second operation. He has no inclination to cough. He speaks well, and sleeps throughout the night. He occasionally has pains in both shoulders.

May 5th : The tumour in the episternal notch is now very firm and resistant. It is much more consolidated than when the examination was last made—viz., on the 23rd ult. The pulsation is much less. The walls of the tumour appear thickened. On auscultation there is still a faint bruit with the first sound at the base, the second sound being accentuated. The murmur formerly heard over the tumour sounds more distant and fainter. The pupils are equal. There is no right radial pulse. Left radial pulse quick and small. From this date onward he progressed rapidly. His appetite improved ; there was no cough or difficulty of breathing, and the tumour became smaller and firmer. He left the Hospital in good spirits.

On July 22nd he was carefully examined, and the tumour was found to have become so small as not to be seen or felt above the cervicle. He is practising his profession again. Can eat and sleep well, has gained flesh, and is in excellent spirits. No morbid sounds are audible within the chest. Right radial pulse is absent.

I have now given you the history and progress of this very grave and interesting case, in which the clinical features are somewhat remarkable, and deserve careful consideration. These are :—1st, the rapid recovery of the patient after undergoing two operations of such magnitude ; 2nd, the comparatively slight disturbance of the cerebral functions that followed the application of the ligature

to the carotid ; 3rd, that the arm regained its normal temperature within thirty-six hours after the subclavian had been tied ; 4th, the progressive consolidation of the aneurismal tumour ; 5th, the rapid healing of the wounds, the carotid operative wound having united soundly by the first intention ; and, 6th, the value of the physical signs in determining the diagnosis of the case. His rapid recovery was unquestionably due to his fine physique and to the strength and tranquillity of his mind, conditions of vital import in hastening recovery. You will remember with what trepidation and despair the patient in our first case submitted to operative treatment. Contrast his behaviour with that of the patient whose case we are now considering. He was as brave as he was hopeful ; and, with every confidence in the resources of our art, he calmly and cheerfully expressed a desire to undergo the operation, although the most momentous issues of life and death were in the hands of the surgeon.*

It was noticed at the time of the operation on the carotid artery that no change had taken place in the area of the pupil of the right eye, and it remained so during the whole time he was under treatment ; and it does appear somewhat remarkable that a free collateral circulation could be established within the cranium accompanied by so little disturbance of the cerebral functions. Then, again, the arm regained its normal temperature within thirty-six hours after the subclavian had been tied, showing the healthy and elastic condition of the arterial system generally, as opposed to the condition known as atheromatous degeneration. The progress of consolidation within the tumour, you will remember, was comparatively slow until the second operation was performed, and then coagulation became more pronounced. How did this take place ? Did the operation on the subclavian still further diminish the volume of blood passing through the aneurism ? Unquestionably it did. Many eminent surgeons are of opinion that the carotid is the only vessel that needs tying in innominate aneurism, "as the increased risk of the subclavian ligature does not appear to be counterbalanced by evidence of equivalent advantage in curing the disease." This expression of opinion is not in accord with

*In innominate as in aortic aneurism it is desirable to avoid surgical measures, if possible, since no operation can be practised without very great danger and the prospect of success, or even of benefit, is very slight. But if the tumour be extending, in spite of the treatment by rest, and especially if it be extending along the trachea, as evidenced by its growth and by the increase of dyspnoea, it is, in my opinion, quite justifiable to tie the right carotid on Brasdor's method, or even, perhaps, to tie the subclavian artery as well.—*Holmes.*

that I have formed as the result of treatment of the cases under consideration, where the most marked improvement succeeded the second operation (subclavian). Now, with regard to consolidation of the sac, how does coagulation take place after distal ligature? Hitherto there has been a general consensus of opinion among the leaders in the profession, that "the distal ligature reduces the force and velocity of the circulation in the aneurism, and thus favours coagulation of the blood." Does this also diminish the tension within the sac, and the momentum of the blood driven by the heart thereto? Unlike the Hunterian operation, it does not; and therefore Mr. Timothy Holmes, of St. George's Hospital, a man of keen observation and matured judgment, advocates the theory, that the clot forms first, on the proximal side of the ligature; by extension it reaches the sac of the aneurism, causing thrombosis therein. If this be so, is it not a cogent reason for applying a ligature to the subclavian as well as to the carotid? I think so, and I should recommend its being done in about a month (if found necessary) after the ligature of the latter vessel.

The report tells us that the wounds healed rapidly, that in the neck having united by the first intention. The subclavian wound, from its great depth and the dorsal decubitus of the patient, rendered the escape of inflammatory products somewhat difficult, although the wound was strictly aseptic. In two or three days we were enabled to change his position, which permitted of a free drain of healthy pus, and the wound healed rapidly. In applying a ligature to an artery in its continuity our object is, first, to cause permanent occlusion of the vessel; and, second, to obtain union of the wound over it as early as possible, in order to control suppurative action and its probable consequence—secondary hæmorrhage. To bring about so desirable a result I secured the arteries with prepared kangaroo tendon; irrigated the wounds with a 5 per cent. solution of carbolic acid, and carefully dried it with sponges. I then secured the edges with silver wire and horse-hair sutures, and covered it with absorbent wool, moistened with styptic colloid, which not only excludes the air, but when dry acts as a support in closely approximating the edges of the wound. With regard to the diagnosis, I think upon that point we were tolerably clear, although some of my colleagues were inclined to think it was aortic on account of the weaker pulse being on the left side. We all know how extremely difficult it is to diagnose accurately an innominate from an aortic aneurism, and mistakes have been made by the best surgeons

of the day, errors which have been made manifest by post-mortem examinations.*

On the whole, I think the physical signs, as set forth in the report, point to the aneurism in this case as having its origin in the innominate artery, and the result of treatment has tended to strengthen the opinion previously formed as to its probable nature. The termination of the case is eminently satisfactory to both patient and surgeon, as showing what art can sometimes accomplish in rescuing from an early grave many sufferers whose ailments at first sight appear of so grave a character as to almost forbid the employment of even palliative measures. You may possibly ask—what have been the factors at work in the causation of this arterial lesion? The patient is a young man, only thirty-three years of age, and has never suffered from syphilis or alcoholism. He tells us that he has had frequent attacks of acuterheumatism, and his father suffered much from gout. He is a veterinary surgeon by profession; has often received blows on the chest from restive horses, and has had to use considerable exertion in throwing them for operative purposes. Four years ago he was garrotted. There may have been an inflammatory softening of the artery, due to rheumatism, which only awaited some mechanical violence, or extreme intravascular pressure, to dilate the vessel at its weakest point, and so lead to the formation of an aneurism.

* "This difficulty," writes Dr. Gross (*A System of Surgery*, Vol. II., 1882), "was strikingly felt in a case which occurred a few years ago in the practice of Dr. Sands, of New York, in a middle-aged woman, a patient in the Bellevue Hospital, who had a soft, pulsating tumour at the root of the neck. It was situated behind the right sterno-clavicular articulation, and extended upward 2 inches above the clavicle, being partly covered by the sterno-mastoid muscle. The patient was carefully examined by a number of the most eminent surgeons and physicians, who all concurred in the diagnosis of innominate aneurism, except one, who thought that the aorta, as well as the innominate, was dilated, his opinion being founded on the presence of a circumscribed spot in the right supra-scapular space, which was dull on percussion, and which transmitted, very distinctly, the aneurismal murmur. On the 16th of July, 1868, Dr. Sands, to whom I am indebted for an account of the case, performed the distal operation, by tying simultaneously the carotid and subclavian arteries. The ligature of the carotid was applied immediately above the omo-hyoid muscle; that of the subclavian was external to the scalene. The patient recovered from the operation, and the tumour diminished in size, the dyspnoea and other pressure symptoms being at the same time relieved, so that hopes were entertained of a permanent cure. Gradually, however, the swelling again increased, and the patient sank from dyspnoea, thirteen months after the operation. At the dissection, a sacculated aneurism was discovered, about the size of a large pear, arising by a narrow orifice from the aorta, directly in front of the origin of the innominate artery. The latter vessel was healthy, and was behind the aneurismal sac, nearly four inches from the external surface."

ORIGINAL ARTICLES.

CASE OF OSSEOUS FORMATION OF DURA MATER.

By C. W. MORGAN, M.D., SURGEON TO NEWCASTLE HOSPITAL, N.S.W.

G. S., *æt.* 32, a West Indian black, cook of the British ship "Leucadia," was admitted to the Newcastle Hospital on the evening of Monday the 4th of August last. His captain reported that on the 28th of July, a week prior to his admission, G. S., ordinarily a very sober man, began to drink, and was more or less intoxicated until the evening of Thursday, the 31st, when the mate of the vessel, finding him drunk and incapable in the galley, had him put to bed. On the following morning he attempted to go to his duty, got out of his bunk and staggered on to his feet—finally fell down and was carried to bed again to sleep off the effects of his debauch. He remained in bed for several days, neither eating, drinking, nor speaking to anyone, but appearing to be torpid. His condition did not seem to excite any apprehension on the part of the captain or officers, who thought he was only "sulky," instances being not infrequent of coloured men refusing their food and keeping obstinately silent for days together.

On the morning of Monday, the 4th of August, or four days from the time he took to his bed, the captain became alarmed about him and sent for Dr. Ashe, of this city, by whose advice the man was removed to the Hospital, where I saw him shortly after his admission. The man lay with his head thrown backwards and to the left side, his teeth were clenched, the muscles of his jaws rigid, the *sterno-mastoid* of the left side in a state of chronic contraction, the expression of countenance suggestive of *risus sardonicus*, but the contortion affecting the left side only; the eyes were fixed and staring to the left, but the pupils were obedient to light; the right arm was semi-flexed and rigid, a general tendency to spasmodic action of muscles of body, the pulse 95, somewhat feeble and hard—temp. 99. There was a tolerably extensive ulceration of lower lip, concerning which I could obtain no history, an abominably offensive smell of breath; had no power of swallowing even fluids of any description. He was said to have neither eaten nor drank anything for a week and to have had no action of the bowels. The bladder was empty

but there were indication of his having voided urine. Ordered aperient enema, to be fed with beef tea, milk and brandy, *per rectum*.

August 5th.—Patient has rested quietly during the night, apparently sleeping, and seems a little stronger, bowels relieved by enema, has passed urine incontinently. There is, however, no consciousness, and the rigidity or tonic spasm of the neck and arms continue; there is no possibility of administering food or medicine by the mouth, the teeth being tightly clenched; this however appears to be not altogether involuntary, as the patient resolutely resists any effort made to cause him to open his mouth. Blisters to nape of neck and temples to be dressed with strong mercurial ointment. Boracic acid dressings to lip. *Afternoon of same day:* Consultation with Dr. Ashe, who believes the man to be shamming to a great extent, and indeed it is very difficult to decide whether such is the case or not. The muscles occasionally relax their tonic spasm, and the expression changes, the eye becoming almost intelligent, and the contorted condition of the countenance giving place to a placid and even rational appearance. At this stage we noticed that the right arm, which has hitherto been persistently rigid, is occasionally relaxed, and the patient will contract either arm if it is inspected or interfered with. Once or twice his mouth has been observed to be open, but on any attempt on the part of the surgeon or nurses to open it still further, the patient resolutely clenches his teeth. To be fed *per rectum* as usual.

August 6th.—Condition remains the same.

August 7th.—This morning a slight swelling is observable on the anterior surface of the right parietal bone, like an incipient "puffy tumour" described by Pott. Patient little altered in appearance, not much weaker, makes no effort to speak or open his mouth; ulcer of lip has healed, fætor of breath diminishing, is still unable to swallow, evacuations of bowels and urine involuntary, food is retained in *recto*, and the patient sleeps calmly and without stertor at night.

August 9th.—The tumour more marked, slightly painful when touched, and patient flinches. A tube passed through the nostril this morning, and a few ounces of beef tea injected *per nares* by gravitation. This proceeding caused great distress; patient struggled, sat up in bed, coughed violently, and opened the mouth widely, and there issued therefrom a quantity of mucus as the result of the coughing. For some time after this operation the patient seemed to suffer very much, and I resolved to continue feeding by the rectum as giving rise to less distress, with as good a

result with regard to the quantity of food exhibited.

August 10th.—The character of the "puffy tumour" leaves no doubt on my mind of the existence of mischief immediately under the swelling, inducing separation of the *dura mater*—suggested to my colleagues the possible justifiability of trephining to explore. It was however decided that such a course was too great a risk.

August 11th to 14th.—Patient becoming gradually weaker, some occasional epileptic fits, not very well marked. On the 14th, became comatose, and sank on the morning of the 15th August, on the sixteenth day of his illness.

Post-mortem.—No external marks of injury to the head. On reflecting scalp a patch of ecchymosis observable under the "puffy tumour" above described. Pericranium non-adherent, and the surface of the cranium darkened and dusky-red in colour in this situation. Calvarium removed and exhibits a discoloured patch about the size of a five-shilling piece, on its internal table, corresponding to the outward discolouration. *Dura mater* exhibits same appearance of dark patch, at the lower end of which there is a perforation leading to a cavity, in the interior of which is to be perceived growing from the inner surface of the *dura mater* a spiculated irregular-shaped piece of bony deposit; the cavity contained no fluid nor matter. On the right side of the *falx cerebri* there is also a bony plate, somewhat like a small limpet shell, and also an irregular spiculated piece of bone. These are on the same plane with an adjacent to the cavity above described. The vessels of the brain were not congested—the ventricles contained a little fluid, probably, post-mortem, the substance of the brain was soft and degenerative. The absence of a definite history, and the peculiar condition of the patient, renders the origin of the special lesion of the brain and the ossific deposit of the *dura mater* one of speculation. It is probable that the primary cause was mechanical injury from a blow. The production of bone in the *dura mater* and *arachnoid* have been repeatedly described.

The case which I now report appears to me to be chiefly interesting on account of the absence of ill-health on the part of the patient until a very short time prior to his admission under the circumstances I have described; and the presence of the bony matter was sufficient to account for a train of symptoms (chiefly indicating irritation of the nerve centres), which were to say the least of them, extremely complex and difficult of solution.

THREE UNUSUAL CASES OF FRACTURE.

By JOSEPH L. BEESTON, L.K.Q.C.P.I. & L.M.,
L.R.C.S.I. & L.M., NEWCASTLE, N.S.W.

THE following cases of fracture are remarkable for the manner in which they were caused, and will be, I think, interesting to the readers of the *A. M. G.*—

H., a man about 33 years of age, was apprehended as a lunatic, and brought into the Newcastle lockup on that charge. He remained the night in the cell, and on being examined the following morning by the medical officer was sent into the Newcastle Hospital for treatment. On admission his temperature was 103.4°, and presented the concomitant signs of meningitis. He lingered two days, and died, after being in a comatose state for twelve hours. The autopsy revealed a fracture of the cribriform plate of the ethmoid bone, from which extensive meningitis arose. I afterwards learned from one of his friends that while on his way to the lockup he had pushed an "Eagle" copying ink pencil into the nostril, after which some hæmorrhage occurred. This, no doubt, was the cause of the fracture, as its edges were elevated from the floor of the skull.

The second case was an oblique fracture of the humerus by muscular violence.

F.B., a delicate-looking boy, of about 12 years, was in the act of throwing stones when, as he says, his arm dropped powerless at his side. The fracture was a well marked oblique, in the upper third of the humerus. Subsequently some large abscesses appeared, due to the laceration of the tissues, which must have taken place at the time of injury.

The rarity of direct violence as a cause of fracture of the clavicle encourages me to place this under "unusual causes":—

R. L., æt. 38, fell, in company with a fellow labourer, from the top of a building on to the ground, a distance of about 30 feet. His companion was carrying a hod of bricks, which fell on L., who was undermost, causing a comminuted fracture of the clavicle, the three fragments of which could be distinctly felt. The case ultimately did well.

QUEENSLAND TICKS AND TICK-BLINDNESS.

By JOS. BANCROFT, M.D., PRESIDENT OF THE QUEENSLAND MEDICAL BOARD.

THERE are many interesting facts that deserve investigation respecting the poisonous effects produced by noxious animals found in this country. I select for description the common "tick," which abounds in some parts of the thickly wooded districts—the scrubs. It belongs to the Arachnida or spider class,—to which, also, belong scorpions, mites, the human itch insect, the scab insect of the sheep, and many other poisonous creatures.

The ticks that live on the dog and sheep in Europe crawl upon those animals when in the woods; they are not destructive to life, but the one here described is to our introduced animals very poisonous, and the dog and cat are frequently killed by it, though it is endured by the native animals without much apparent injury, as one finds them carrying numbers of ticks, and yet in possession of great muscular power and activity. The tick varies in size from the smallest point to a quarter of an inch, and when distended with blood is often half-an-inch long, and nearly of the shape of a castor oil seed. From this resemblance the castor oil seed was called by the Romans *Ricinus* (Eng. tick), and the castor oil plant is now called *Ricinus communis*.

The ticks are found on men and animals after walking through the scrubs, and in some parts they abound to such an extent that it becomes a serious matter to remain in their strongholds. Contact with an animal of large size is an event in the life of a tick not to be disregarded. Its carnivorous propensities now come into vigorous action; in a short time it penetrates the skin, sacrificing its powers of locomotion to enjoy a continuous feast on the blood of its victim.

The tick generally seizes upon the soft folds of the skin—about the neck and ears of dogs, and in men about the neck, groin, and armpit. In attaching themselves to the skin, they produce little pain, and are rarely noticed; but shortly afterwards a small inflamed point results, which the uninformed mistake for a small boil.

Persons familiar with the tick can tell by the peculiarity of the pain when the inflamed point is touched that he is suffering from a tick-bite. He then seizes the tick between his nails, and plucks it off.

How so small a creature can attach itself with such force to the skin is understood by referring to the microscopic structure of its beak.

The beak, or penetrating organ, is a fiftieth of an inch long, and consists of two outer valves which form its sheath. The central body is conical, and covered with minute barboles pointing backwards—all arranged in rows of about twelve, and of these rows there are six; so on this small organ we find upwards of seventy barboles. Applied to the sides of the penetrator are two finer instruments without barboles except at their points, where there are five. These organs I consider assist in penetration, by attaching themselves in the first instance so that the tick then has some support by which he can press forward the central penetrator.

The feet are not a little curious and consist of an oval elastic pad, to the margin of which we find two fine hooklets. By means of the barboles on the penetrator, the attachment becomes more or less permanent, and it would appear that the tick, once adherent, cannot disconnect itself. Ticks, however, can detach themselves from the integument to which they adhere, as may be proved by putting a piece of skin on which ticks are fastened under a glass. A piece of iguana skin under a tumbler is convenient for experiment. In a few hours the ticks discover the absence of their wonted supply of food, unhook themselves, and walk away. That circumstance would probably occur in some instances by ulceration of the structure into which the tick had penetrated, but to the native animals, as for instance the iguana, the attachment is of long duration and does not appear to be injurious. A part of the penetrator is always left behind when a tick is forcibly pulled out.

A popular idea is that the tick burrows through and lives underneath the skin, and though that is the case with some arachnida—as the itch insect—it is not so with the tick. Swelling of the surrounding tissues, however, may—as in the armpit, nearly bury the tick.

A bandicoot once shot by me, was directed to be skinned; ticks were found on its skin, and I was told under it also. The underlying ones on examination were found to be metallic.

In a short time after the attachment of a tick some slight pain and swelling results, which is often neglected. The tick fills with blood, and the pain increases, until in the human subject it becomes so severe as to attract notice. Some time ago I removed one from a gentleman that had been attached a fortnight. It was half-an-inch long, and had caused considerable pain and swelling of the neck, together with a sense of debility.

The results upon the dog and cat are more

serious and demand particular notice. All dogs that have been in the scrubs are very liable to be attacked by ticks, especially if they have long hair. If these are not removed in the course of three or four days death may be expected. They may be felt attached to the skin about the neck and other parts the dog cannot reach with his teeth. All dogs, large or small, should be carefully combed and watched for several days, to see if tick-poisoning presents itself. I have never seen pups recover after this has appeared. In full grown strong dogs the following symptoms present themselves. In two or three days after the attachment of a tick, the dog begins to look weary. The cat in addition by not washing itself appears dirty. Food is refused and soon after, drink. The animal lies down, and seeks for that purpose some place where he can remain undisturbed. Pups travel away and are rarely again found alive. The dog responds to the call of his master, but will not follow him far; shortly weakness in the hind legs is observed, and in about five days from the attachment of the tick the animal becomes unable to walk, and may at times be seen to be timid and delirious. On attempting to rise up on his fore-feet he may fall over insensible—in a few minutes he recovers his consciousness. On observing closely one of these attacks, it will be seen that the lips of the dog are pale, his heart can scarcely be felt to beat, and the condition of fainting is clearly noticeable. During all his illness there is the greatest reluctance to take food or drink, and forcible feeding brings on his fainting attacks. He tries to creep out of sight by the help of his fore-legs, and in a few days at the farthest dies in one of the attacks. Old dogs endure much longer than pups, and if the tick has been removed early, recovery may be hoped for.

The only cat I have seen suffer lay unable to walk for a week. She was forcibly fed with milk during the time, and made a slow recovery. Cats are said to have nine lives.

The action of the tick poison I consider to be similar to that of the snake. The poison, however, produces its effects more slowly and is also more slowly got rid of by the excretions.

The cause of death appears to be chiefly if not entirely from muscular paralysis, produced by a poisoned condition of the fluids. Those muscles most remote from the centre of circulation and which receive the least supply of blood suffering most from the paralysis. The hind legs are the first to lose their power, the fore-legs next, and lastly the heart. Death taking place from want of the power of contraction in that organ.

The poison appears to reside in the salivary secretion, as it does in sand flies and mosquitos.

The tick-proof state of constitution that the domestic dog occasionally arrives at by repeated tick poisonings of a mild form is very interesting. In this ability to endure ticks he then resembles the native animals.

TICK-BLINDNESS—I noticed last year in the human subject, though I suspected it in dogs for a long time.

A married woman of about forty came with a tick attached to the skin near the ear. She complained of weakness, fear of falling on stooping or erecting herself. I removed the tick, and prescribed tonics. She could not distinguish persons in the distance, and could only read half-inch type with difficulty. The iris moved correctly. There was no pain or inflammation of the eye, the retina was normal, and with the most careful scrutiny the amblyopia was the only error noticed. She was seen frequently. The other nervous defects disappeared in about a fortnight, after which her sight gradually improved, and in a month she could read ordinary newspaper type.

A METHOD BY WHICH ONE CAN SEE THE SHADOWS OF ONE'S OWN RETINAL VESSELS AND YELLOW SPOT.

By W. ODILLO MAHER, M.D., SYDNEY; LATE HOUSE SURGEON, ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.

Of the several methods known by which one can see the shadows of one's own retinal vessels and yellow spot, Purkinje's is probably the most satisfactory. Lately I have discovered a method by which, in my opinion, the image of the retinal vessels can be more readily and distinctly seen, and by which the shadow of the fovea centralis, which is with difficulty made out by Purkinje's method, is well defined and easily recognised. I am not aware that this method has ever been described, and I consider it worth recording. In several respects it resembles Purkinje's, but in some essentials it is entirely different. To these I shall advert later on.

Standing at a short distance (ten or twenty feet) from a lighted gas jet in a dark room, and covering one eye, say the left, with the left hand, the observer takes between the forefinger and thumb of the right a strong convex lens, and holds it at about its focal distance in front of the right eye. Then, steadily gazing at the light through the centre of the lens, he shakes the lens rapidly backwards and forwards along its axis, or

up and down, or from side to side. After a few seconds the shadow of the fovea centralis appears in the axis of vision as a light yellow patch studded with dark coarse granules. Simultaneously the retinal vessels in the region of the yellow spot, including the finest capillaries, appear as dark cords against the yellow light. The appearance is not unlike the plate (No. 72) in the last edition of Mr. Nettleship's book on diseases of the eye, except that the difference between the arteries and veins is not so marked, and that one gets a more extensive view, seeing the shadow of the retinal vessels as far as the optic disc. The outline of the shadow of the fovea centralis, which falls upon the most sensitive part of the retina, the yellow spot, is well defined; whilst the outline of the shadow of the optic disc cannot be distinctly seen, as it falls upon a much less sensitive part of the fundus. The shorter and more rapid the movements of the lens the sooner the shadows of the retinal vessels and fovea centralis appear, and the more distinctly are they seen.

This is a simple and easy way of demonstrating:

1st. That there are no blood vessels in the fovea centralis.

2nd. That the structures in which the visual impulses originate must be behind the retinal vessels.

3rd. That the fovea centralis differs in structure from the other parts of the retina.

In conclusion, I shall briefly describe Purkinje's method, and point out the differences between it and that which I have described.

Purkinje's Method.—Whilst looking at a dark ground in a dark room one concentrates with a lens the rays of light from a gas jet, and throws them obliquely on the sclerotic immediately behind the sclerocorneal junction, or on the cornea itself. On rapidly moving the lens up and down or from side to side, one then sees projected on the dark wall the image of the retinal vessels.

The main points of difference between this and the method described by me are:—

1st. That the rays of light are not thrown obliquely on the sclerotic or cornea, but are directed along the visual axis, and consequently fall perpendicularly on the surface of the cornea.

2nd. The image of the retinal vessels is not projected on a dark wall, but is seen against the yellow light.

3rd. The shadow of the fovea centralis is faint and difficult to recognise by Purkinje's method, whereas by this method it is as clearly defined and as easily seen as the shadow of the retinal vessels.

ASSOCIATION INTELLIGENCE.

SOUTH AUSTRALIAN BRANCH.

MONTHLY MEETING.

Held at the Adelaide Hospital, September 4, 1884.

The President (Dr. C. Gosse) in the Chair.

THE minutes were taken as read and confirmed. Mr. Corbin then referred to a resolution carried at the last meeting, relative to taking steps to have fuller information published in the official lists of medical practitioners in the colony. He stated that the matter had been discussed since then, by the Medical Board, with the result that the latter did not feel justified in taking upon itself the responsibility of any action in the matter, but that the President of the Board (Mr. Moore) would convey to the Honorable the Chief Secretary, the fact that a section of the medical profession were desirous of the additional information being published.

Dr. C. GOSSE informed the meeting that the Council had not yet done anything, as Mr. Corbin had asked him to postpone taking action until after the Board had met, as he hoped the change might be effected without further trouble. It was evident, however, from what Mr. Corbin had just reported, that the Board was going to do nothing. He objected to the Association being called a section of the profession, as he thought it very fairly represented the views of the medical men generally throughout the colony. It was now for the meeting to say what should be done.

Dr. PATERSON said he was not present at the last meeting of the Medical Board. He thought, however, that if it was the wish of the majority of the profession that this fuller information respecting qualifications should be published, the proper thing to do was to put into effect the resolution carried at the last meeting.

Dr. C. GOSSE seeing that this was the wish of the meeting, stated that the deputation would be formed without delay.

Dr. Robertson was elected a member of the Branch.

Dr. GARDNER moved that by-law 7 be altered to the effect that the meetings be held monthly, excepting in December. He said the object of this proposed change was to place more evenings at the disposal of the Council, so that it might the better carry out the resolution respecting discussions without interfering with the other business of the Association, which was always increasing. The motion was seconded by Mr. Clindening and carried unanimously.

EXHIBITS.

Dr. Poulton exhibited—for Mr. Ellison—a boy, aged thirteen, who had been the subject of excision of the right scapula in its entirety for osteo sarcoma involving the venter.

When admitted under Mr. Ellison's care last June, the right scapula was the seat of a painful, evenly projecting swelling, supposed by the boy to be consequent on a severe strain received some months previously. Nine days after admission the tumour had sensibly increased in size, was more painful on palpation, and was indistinctly fluctuant, a malignant, bony growth was diagnosed.

On July 7, under ether and using full antiseptic precautions, Mr. Ellison removed the scapula; a T incision was made. After exposing the tumour, a trochar was inserted, no fluid escaped. The greater part of the scapula was removed by sawing through the spine, &c., obliquely. The shoulder joint was then opened, the acromio-clavicular articulation divided, and

the fragment drawn forcibly backwards, putting the tendons inserted into the coracoid process on the stretch. These were then divided and the whole bone removed.

The venter of the scapula was found to be perforated and the subscapular muscle to be involved in the growth. Patient has done well, except some delay in the process of cicatrization. He can now feed himself, carry light weight, easily lifts a ward chair with little difficulty, and presents remarkably little deformity.

Dr. Gosse exhibited a patient, aged 9 years, who had an intra-ocular tumour of the left eye. The growth, which consisted of two very smooth hemispheres, with a large vessel running in the sulcus between them, was of a pale yellowish colour. It appeared to be a detached retina. There was an interesting point to decide whether the growth was a glioma, or some collection of fluid behind the retina.

PATHOLOGICAL SPECIMENS.

Dr. Gardner exhibited an hydatid cyst, removed from the female breast.

Also a stone weighing 5 drs. 35 grs., removed by lithotomy at one sitting (Bigelow's instruments).

Also a gold plate with one tooth and five prongs, removed by oesophagotomy.

Also a larynx showing diphtheritic membrane.

Mr. Dunlop showed a large perforating ulcer in cardiac curvature of stomach, 2 in. long by $\frac{1}{4}$ in. wide. Perforation large enough to admit passage of ordinary horse bean. Patient got up five mornings before death in excellent health. Had sudden excruciating pain in abdomen, and became collapsed. Died of general peritonitis.

Also a brain showing acute tuberculosis, with large quantity of lymph coating base, due to meningitis.

NEW SOUTH WALES BRANCH.

THE 46th General Meeting of the Branch was held in the Royal Society's Rooms on Friday, 3rd October 1884, at 8.15 p.m. Dr. Quaife, president, in the chair.

The PRESIDENT announced that Dr. D. Collingwood, of Summer Hill, had been elected a member of the Branch.

Dr. FOREMAN read a paper for Dr. C. Morgan, of Newcastle, on a case of "Osseous Formation of Dura Mater," with exhibit, which will be found on page 35.

Dr. QUAIFFÉ said he recollected a similar case to the one reported by Dr. Morgan, which occurred in Paddington. It was that of a lady of whose death suspicions were entertained that it was due to poison. She had been subject to epileptic symptoms, and her death, on a post-mortem examination, which revealed somewhat similar osseous formation to Dr. Morgan's, was shown to have arisen from this cause.

Dr. FOREMAN exhibited an Interstitial Fibroid Tumour of the Uterus, weighing about 12 ounces, which he had removed by enucleation without division of the cervix, having dilated the os uteri by means of Barnes' bags. The patient made a good recovery. She had at intervals suffered so severely from hæmorrhage as, on one occasion, to necessitate transfusion of blood direct from her husband, by Roussel's method.

Two ovaries removed for prolapse into Douglas' Pouch, with retroflexion of the uterus, the patient making a good recovery, leaving the hospital on the eleventh day. The ovaries, which were removed through the vagina, were enlarged, and the tubes enormously hypertrophied.

VICTORIAN BRANCH.

ORDINARY MONTHLY MEETING.

Melbourne, Wednesday, 15th October.

Hall of the Royal Society.

The President, Mr. Rudall, in the chair.

CORRESPONDENCE.

A LETTER was received from the General Secretary, inviting short abstract reports of the proceedings of the Branch.

CROWDED LUNATIC ASYLUMS.

The Honorary Secretary submitted letters from the Secretary of the Central Board of Health, relative to the resolution passed at the last meeting of the Branch on the crowding of the lunatic asylums of this colony. The first of these communications expressed a doubt as to the power of the Central Board to interfere, and the second reiterated that doubt, but also opined that, as the whole subject of asylum management was at present under consideration by the Lunacy Commission, it was inexpedient to take any action until the final report of the Commission had been sent in.

A communication was also submitted from the Secretary of the Lunacy Commission in acknowledgment of a copy of the same resolution as that sent to the Board of Health.

The following paper was then read:

ON A CASE OF ABNORMALLY LOW TEMPERATURE IN ACUTE DOUBLE PNEUMONIA.

By ROBERT DENHAM PINNOCK, M.B., CH., M., GLAS., SURGEON TO THE BALLARAT HOSPITAL.

THE following case may be of interest as illustrating the occasional occurrence of Acute Pneumonia with very slight elevation of temperature.

The patient, Mrs. P., æt. 46, married, housewife, became chilled after perspiring freely, and had the lower two-thirds of her right lung inflamed with the usual accompanying symptoms, well-marked on the 18th June.

Her highest temperature on this day was only 99° F. On the 14th it was 99·1. On the 15th the lower half of the left lung became inflamed also, and on this day the highest temp. was only 100·5.

Afterwards as follows:—16th, 99·5; 17th, 99·6; 18th, 97·6; 19th, 97; 20th, 98·4; and on this day the right lung began to clear in patches.

From this date to the 29th June—when both lungs were clear—the temperature remained at the normal point.

The treatment pursued was cold water compresses to the whole of the chest and back and aconite internally until the temperature fell to normal. Afterwards Tr. Iodi externally, and Pot. Iodide and Hydrarg-Perchlor. in small doses internally until expectoration became free, when she had the ordinary Ammon. Carb., Tr. Scillæ and Decoct. Senegæ mixture. I have a large record of temperatures in various inflammatory and other complaints, but have never yet met with such a record as the above in a well-marked case of acute double pneumonia.

In the discussion which ensued, it was considered that the paper was incomplete, lacking any particulars as to the pulse. There was no certainty, it was said, that the case was one of pneumonia at all, as the change of tissue involved in true pneumonia of necessity would cause a marked rise in the temperature. It was thought too, that some information should have been supplied by the author as to the exact kind of the wet compresses used.

The following paper was then read:

ON A CASE OF SEMI-LUXATION OF THE CERVICAL VERTEBRÆ.

By THOMAS PENNINGTON LUCAS, L.R.C.P., ED.,
M.R.C.S., ENG., &C.

C. H., a lad of 9 years of age, was brought to me suffering from the effects of a fall occasioned while playing at leap-frog. While bending his body forward, he had been thrown down by the boy vaulting over him, his head having come forcibly in contact with the ground, and to one side. I found the neck arched to the left side, and when I touched the spine he screamed, and shrank from any further examination. The right side of the neck was stretched and the head was fixed, and could be moved only with the thorax. I could not detect any protrusion backwards. The breathing was hurried, but not stertorous. He could not look upwards; the face was towards the ground, but not directly to the feet, at an acute angle. I found that the mischief was certainly above the 7th vertebra, probably about the 4th or 5th. The pulse was rapid, and the boy perspired freely on account of the dyspnoea, and was much excited.

Being satisfied of the semi-luxation, I placed the patient in a chair and took up my position behind him. I then placed my hands on either side of the head, over the petrous bone, and raised the head as if to hang him. I then gave a sudden and sharp jerk upwards, and to the right. There was a slight jar, and the boy immediately shouted out, "I am better." I was at once enabled to incline the head in any direction, and the boy appeared quite relieved. There was some soreness for two or three days, but with the application of an evaporating lotion it passed away. The muscular strain soon passed away too, and he has experienced no subsequent inconvenience. The injury occurred five hours before he was brought to me. There was no paralysis whatever.

In the discussion, the President remarked upon the rarity of recovery in such cases. The process of reduction of such forms of dislocation was generally considered to be best effected by a lateral motion. He referred to Mr. Simons' case, in which a girl, after living 15 days subsequent to the receipt of such an injury, suddenly dropped dead. In that case dislocation was found.

REVIEW.

DISEASES OF THE HEART AND THORACIC AORTA.

By BYROM BRAMWELL, M.D., EDINBURGH: YOUNG
J. PENTLAND, 1884.

THIS book of nearly 800 pages and containing some 300 illustrations is one of the most comprehensive works we have seen. It is the fruit of many years of labour. Let the preface speak for itself. "The lithographs of naked-eye objects, represent with few exceptions the hearts of patients who have been under my own care during life, and with whose clinical histories I am intimately acquainted. The microscopical lithographs are, with two exceptions, copied from sections made by myself. In order to ensure absolute accuracy of representation, the naked eye specimens were first photographed, and then drawn under my immediate personal supervision, while the microscopical objects have been placed directly on the stone from my own drawings." This is just the sort of work one would expect from the author of "Diseases of the Spinal Cord" which appeared but two years ago.

In an opening chapter on the anatomy and physiology of the heart, is given a resumé which is brought up to date. The author leans to the views recently enunciated chiefly by Gaskell in England, that the rhythmical action of the heart is not entirely due to the periodical and orderly discharge of motor nerve force from the intra-cardiac ganglia, but that it may be in the human heart as it certainly is in that of the tortoise, that the muscular fibre itself has an inherent power of rhythmical contraction. This chapter is an excellent statement of the subject and is an earnest of what is to follow.

The article on Ulcerative Endocarditis may be taken as a fair example of the rest of the work, and here the copious illustration is well seen. The relation of micrococci to the affection is discussed without too much space being given up to the discussion. He sums up "ulcerative endocarditis does not appear to be a specific infectious disease in the same sense that typhoid, scarlet fever, and small-pox are, for, so far as I am aware, inoculation experiments have failed to reproduce the disease. In some cases, the endocardial lesion appears to be a manifestation of a general pyæmic or diphtheritic condition. . . . In other cases the cardiac lesion is the primary local source through which the system becomes impregnated . . . micrococci, which we must suppose are always circulating in the blood, but which in a state of health are unable to multiply and establish themselves in the tissues, find a suitable soil, and develop first in the cardiac vegetations and subsequently in distant organs and parts."

A feature of the work are the coloured plates of microscopical preparations, recalling the plates of Woodhead's Practical Pathology, lately issued by the same publisher. These give an excellent idea of what a preparation looks like under the microscope, although in the matter of details the plain woodcut shows up better; but both are numerous in the book, so that the coloured pictures are useful as well as to some extent ornamental.

Taking it as a whole, we think it is a splendid work, and one which we confidently recommend to the profession in Australia.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, NOVEMBER 15, 1884.

EDITORIALS.

THE CASE OF DEATH AFTER INHALATION OF ETHER IN THE ADELAIDE HOSPITAL.

IN connection with the death of a patient in the Adelaide Hospital after the administration of ether, a section of the lay press seems to have displayed some amount of censure in adverting on the unfortunate occurrence.

The facts of the case are simply these :—An elderly woman named Marion Kelly, ætæ 58, was knocked down in the street by a drunken man, the result being that she sustained an intra-capsular fracture of the femur.

This occurred on September 16th; then, according to the newspaper report, her relatives were running about to obtain medical assistance, and this was not forthcoming till the afternoon of the next day, when she was seen by a surgeon who ordered her removal to the hospital, though we are unable to glean why this delay in obtaining medical aid occurred.

The woman was admitted to the hospital on September 17th, and in the Ward Case Book it is recorded that no full examination was made that day, on account of the pain.

On the 18th another attempt was made to examine the limb, with the object of applying the long splint, if deemed advisable; but here again the pain was too severe.

On the 19th ether was administered and the diagnosis confirmed, when the unfortunate accident occurred.

At the post-mortem examination it was revealed

that the deceased had a fatty heart, and that there was also a large biliary calculus.

The point urged in the leading article of the *S. A. Register*, is that the poor woman was "done to death, partly through violence, partly through the administration of ether while she was in a state unsuited to such treatment."

Now, as the fact that she was admitted to the hospital on the 17th and was not placed under ether till the 19th is strongly criticised, we presume that the writer surmises that she was in a fit state for the administration of ether on the day of admission.

Then, again, the propriety of placing the patient under ether with such a heart is warmly discussed, but what could be more unfair? There is no option in questions of this kind. If the exact condition of the heart could be accurately known during life, and if all the weight of medical evidence was against the administration of an anæsthetic in such a condition, even then it would be our duty to relieve suffering humanity almost in the death throes, from the pain and shocks of some unlooked-for accident.

In the present state of medical science, we must admit that a fatty heart is not always discoverable; certain symptoms point to such a condition and we can only surmise that it exists; and further, if we have a case which leaves no room for doubt, it is universally admitted that an anæsthetic may be given, and that ether is the best one to use.

In a case such as this, intra-capsular fracture, by the use of such an agent as ether, we alleviate pain and avoid the intense suffering which must be unavoidably caused in making the necessary examination, believing, as we do, that the risk of death to a patient with a faulty heart, from the shock, would be greater than from the anæsthetic; in other words, we know that death may result from shock alone if an anæsthetic be not employed.

Lastly, it must always be borne in mind that patients under an anæsthetic sometimes die from causes wholly extrinsic to its administration, an unfortunate coincidence of which many cases are recorded. Again and again the death of a patient under an anæsthetic is fully reported in the lay papers, the result being that for a time a panic sets in amongst the community. This is particu-

larly noticeable in a general hospital, where important operations are sometimes postponed as a sequence of these reports.

An anæsthetic which is absolutely safe has not yet been discovered, and meanwhile it is our bounden duty to do what is best for our patients with those means we have in our hands.

QUACKS AND THE PHARMACEUTICAL BOARD OF N. S. WALES.

THE report of the evidence taken at the inquest held on the body of Agnes Rochford at the Court House in Campbelltown, New South Wales, on October 9th, reveals a most astonishing state of affairs, and shows how necessary it is for the public well-being that some act for the regulation of the practice of medicine in New South Wales should be passed. It appears that a post-mortem examination showed that the girl died from rupture of an abdominal tumour, and that under the circumstances no treatment could have benefited her. Nevertheless, the evidence given by a person called Thomas Hamilton Clarke is astounding, as showing the cool impudence possessed by men who, without the slightest professional training or education, commence the practice of medicine as an easy way of earning a livelihood. Can it be for a moment doubted that it would be for the public good and for the advantage of the very people themselves who consult such men that it should be made illegal for them to do so? Believing that the evidence of the man himself will be more telling than any comments we can make, we republish the more extraordinary portions, leaving it to our readers to draw their own conclusions :—

"The first witness called was Thomas Hamilton Clarke, who, having been sworn, stated : I keep a shop in Campbelltown for the sale of drugs and patent medicines ; I am in the habit of attending people at their residences ; about 12 o'clock midday yesterday, the 8th instant, I was called to attend deceased ; came to the conclusion that she was suffering from inflammation of the bowels ; I sent, for her to take, a dose of medicine ; called again about two hours afterwards ; her mother, whom I then saw, wished to take her home by train and asked my advice, and I told her not to do so ; I then left, leaving word that should the girl get bad

again they were to let me know ; about midnight I was again sent for to see her, but on my arrival she was dead ; that would be about 12 o'clock ; I have no legal medical qualification whatever, nor was I trained or taught medicine, nor ever attended a lecture or hospital course ; I base my claim to practice on the fact that I have been doing so some time, and have papers from people to show that I have treated them successfully ; I keep a copy of all the prescriptions I make up ; it is about fifteen years since I first began to dabble in medicine ; I was in Picton at that time, a contractor for making roads and drawing timber for Government ; I worked at that for two years, and then by a public request of the inhabitants I was invited to give up all work and start practice as a medical man, and have been continuously so engaged ever since ; have been twelve months so engaged in Campbelltown ; * * *

produce a book in which is a copy of the prescription I made up for the girl ; the prescriptions in this book are copies I have made from time to time from doctors' prescriptions ; I have no note or anything to show of the treatment in this case, except that I made up one of the doctors' prescriptions which I had previously copied into my book, and I have frequently made it up from the copy before ; this prescription that I copied contains syrup of rhubarb one ounce and a half, tincture of opium two drams, essence of peppermint six drams ; I gave the eighth part of this to the patient to be taken in two doses ; keep a bottle of this strength made up, and use more or less from it ; I never depend on myself, and never think of making up a prescription of my own ; I merely make up from those I have copied ; keep no note book, case book, or any account of cases whatever ; have never been reprimanded by any authority, nor ever accused of manslaughter in any case I ever attended ; have used this prescription before in cases where pains in the bowels were complained of and it relieved them ; took it for granted that she was suffering from inflammation of the bowels from the pains she complained of and touching her with my fingers ; her mother told me that the girl had been suffering more or less from pains for the last six months ; she had great shortness of breath, that would be due to inflammation of the bowels ; from my experience I could tell that it was inflammation of the bowels ; am not an apothecary, or never served any time in a chemist's or druggist's shop, but yet I hold a certificate as a member of the Pharmaceutical Board of New South Wales ; got it four years ago ; was never examined or any test of knowledge applied ; simply got it on recommendation ; had to pay membership fees back from the first, that is, though only four years a member, I had to pay eight years' membership fees."

We think that further comment is unnecessary, except that some explanation from the Council of the Pharmaceutical Society of New South Wales is due to the profession and to the public of the colony, with a statement as to the number of men of this class who hold similar certificates from the society. The addition of their names and that of the place where each of them is keeping a dispensary would enable practitioners to advise their patients of the risk they run by taking their prescriptions to these men to be dispensed.

At a recent meeting of the Ladies' Benevolent Society at Rockhampton (Q.), a motion was passed to the effect that a girl, nearly blind from extensive leucoma, should be handed over for treatment to Professor R., an itinerant, not legally qualified, practitioner, who had expressed his readiness to undertake the case for a remuneration of six guineas, and it was further resolved that the committee should endeavour to induce the self-styled professor to treat the girl without charging a fee, but should he decline to do so, to collect the amount asked for.

We are not aware whether this Society receives aid from the Queensland Government; if it does, its action requires prompt attention from the authorities; under any circumstances, we are of opinion that the proposal of the committee is neither in the interests of the unfortunate child nor of the subscribers to the funds of the Society. At the next general meeting it is to be hoped this action of the committee will be reviewed and, if there is a majority possessed of common sense present, emphatically condemned.

A CORRESPONDENT residing in a town in Northern Queensland, writes to us as follows:—"An American lady has been publicly lecturing here on diseases of women, to ladies who can afford to pay 5s. for admission; she also advertised that she could be consulted free of charge, but then she sold uterine supporters at the same time at an exorbitant price. I sent my wife to two lectures from curiosity, but I could not induce her to hear any more. The lectures, two of which were free were for ladies only, and the lecturer explained to her audience how they could examine themselves to find out if they had any disease of the womb. Girls of from 13 years upwards, only some of whom were accompanied by their mothers, were present to listen to these abominable exhibitions—for such they were, as a great number of models and diagrams of female diseases were shown. What will it lead to if these young girls, frightened by the misleading description of uterine diseases which this woman gave them, examine themselves and then each other? For even in young ladies' colleges, I am told, girls of from 8 to 10 years talk freely about those things which their mothers only should tell them when they are about to get married. All modesty, shame, and purity of thought, so much valued and admired in women, will be destroyed by such lecturers and by so-called advice and consultation, merely to fill the purse of some unscrupulous adventurers. Is there no law in the land, and is the medical faculty in the colonies so powerless that such scandalous, immoral, and

indecent public exhibitions of quackery cannot be stopped?"

We have nothing to add to this except to recommend the subject to the thoughtful consideration of our readers, and implore them to bring all their influence to bear on the authorities to put an end, if possible, to this disgraceful state of things.

ETHER IN SNAKE-BITE.

SIR JOSEPH FAYRE, K.C.S.I., F.R.S., &c., the distinguished author of "Venomous Snakes of India," has written from Dunrobin Castle, Sutherland, to the editor of the *A. M. G.*, with regard to the latter's suggestion of administering ether in cases of snake-bite, as published in our issue for July last. Sir Joseph's views on the subject are expressed in the following extract from his letter to Dr. Creed:—"You are quite right in your estimate of the effect of fear and the moral effects in the cases of many who are bitten. I think it probable that the mode of treatment you suggest might be of use in cases where only a limited dose of the poison has been inoculated, but I fear in cases where a full dose of cobra poison has entered the circulation, that we can do little, if anything, towards averting a fatal result. I hope you will give the ether a good trial and let me know the result."

It is very gratifying to us to find that our journal is read and appreciated by many eminent men on the other side of the Globe. Among others, by Dr. Benj. Ward Richardson, F.R.S., who in his letter to the editor, referred to in our last issue, says:—"Your *Gazette* shows great literary skill and industry, and does sterling credit to the profession in Australia."

Sir Henry Thompson, F.R.C.S.E., it appears, also reads the *Gazette*, as he, having seen in the July number of the *A. M. G.*, the paper on "Digital Exploration of the Bladder," by Dr. Rowling, Honorary Surgeon to the Parramatta Hospital, has presented this gentleman with a copy of his latest work, entitled "Tumours of the Bladder," with the inscription:—"To Dr. C. E. Rowling, with Sir Henry Thompson's best compliments and sincere congratulations."

LEADING ARTICLE.

MASSAGE.

BY REUTER E. ROTH, M.R.C.S.E., COLLEGE STREET, SYDNEY; LATE OF THE ROYAL CENTRAL INSTITUTE FOR GYMNASIICS, STOCKHOLM.

VARIOUS movements for curative purposes have been used from time immemorial; these movements form the so-called *materia medica kinetica*, and are divided into two main classes—active and passive movements. To the latter belong what is termed the treatment by Massage.

The word Massage is of quite recent introduction; it is derived from the Arabic, Mass—to full, the Arabic word being most probably obtained from the Greek Masso, whence also the Latin word Massa, and the German word Massein, are derived.

The principal manipulations comprised under the term Massage, were practised in China more than 3000 years ago (*Abrégé chronologique de l'Empire chinois*. P. Amiot). In India it was known as Tshânpuâ, whence the word "Shampoo" is derived. From India it was introduced into Persia and Egypt. The Greeks termed it "Tripsis," and made use of it after violent active exercise, probably in the same way as an athlete in training is, nowadays, rubbed down. By the Greeks it was introduced amongst the Romans, who employed Massage in connection with their baths, and also as a therapeutic agent.

It then fell into disuse. Soon after the Crusades, it was introduced into Europe as an adjunct to the Oriental Baths. Apart from this, "muskelnadning," or muscle-kneading was known amongst the peasants in Sweden and Finland from time out of mind (*Hartelius, Tidskrift i gymnastik*).

Since then various renowned medical men, amongst them Fuller and Tissot, took a special interest in the treatment by active and passive movements. In Scotland, Reveridge started an Institute for this treatment, where he employed ten rubbers of both sexes.

At the beginning of this century—T. Mezger, a Dutch physician, made a special study of Massage, and it was due to him that Massage

was recognised in Sweden as a valuable therapeutic agent.

Since 1813, Stockholm has been the home of this treatment, when the Royal Central Institute for Gymnastics was founded by the immortal Ling, and where all branches of gymnastics, viz.: military, educational, æsthetic, and medical have ever since been practised and taught.

During the last 35 years similar institutions, both public and private, have been established in various parts of Europe and America, in which various chronic diseases are successfully treated by active and passive movements.

In Europe there exists a certain class of people, known as Medical Rubbers, Shampooers, Masseurs, Magnetisers, &c., who use empirically various manipulations termed, according to fancy, shampooing, rubbing, &c. In connection with their treatment they "rub in" various applications of their own invention. In fact, a case is reported of a "rubber," who on learning that a rival rubber was using oil, and another vinegar with great success, hit upon the bright idea of using oil, vinegar, mustard, salt, and a dash of pepper. I believe he made a small fortune out of this "dressing" for his patients.

Medical men having heard much of the advantages to be derived from Massage as a therapeutic agent, and knowing very little of its practical application, unfortunately sometimes recommend their patients to the tender mercies of these people.

Now, for a person to apply Massage with advantage, it is absolutely necessary that he possess a knowledge of anatomy and physiology, and have had a practical training in applying the various manipulations, in order to know whether he is to "work" on a nerve, a muscle, a vessel or some special organ, in what direction, whether with much or little pressure on the parts, and what parts of the hands are to be used, such as the finger-tips, the palms of the hands, or the closed fists.

Massage has a separate special action on the circulatory, the muscular, and the nervous systems.

CIRCULATION.—When a part of the body, especially a limb, be rubbed or stroked, different results are obtained, according to whether the rubbing or stroking be in a direction towards the heart or in a direction away from it.

In the latter case, the stroking or manipulation encourages the flow of the arterial, and retards the return of the venous blood, causing a determination of blood in the parts beyond where the Massage has been applied. In this way a part receives more nourishment and hypertrophies as a consequence on the increased

amount of blood supplied to the part. In addition, the smaller arteries and the capillaries become distended with the excess of arterial blood, and increased warmth of the part ensues. In a similar manner blood can be drawn from the trunk to the extremities and so relieve organs abnormally engorged with blood.

When Massage is applied in a direction towards the heart, the reverse takes place, the arterial flow is retarded and the venous encouraged. The nutrition of the part is impaired and increased, absorption of tissue and loss of heat is also a consequence. This driving away of the blood is well seen when a leg is elevated and rubbed in a direction from the toes towards the thigh, the blood is driven out and the limb becomes pale and cold, whilst if the leg be depressed and rubbed in a reverse manner from the thigh towards the toes, it soon regains, perhaps in excess, colour and warmth.

Pressure, when firm and continuous, causes atrophy, due to impaired nutrition of the part following on the obstructed circulation. This is continually seen amongst people who wear garters, on whose legs a depressed ring of absorbed tissue is created, due to the continuous pressure of the ligature. A similar ring of absorption is also noticed on the foreheads of people whose hats fit tightly.

Gentle friction is useful by causing absorption of effused blood; this can be seen if adopted in cases of Ecchymosis.

MUSCLES.—Manipulations affect the muscles by increasing or diminishing their blood supply, by mechanically stimulating the muscle fibres, by irritating their nerves and by reflex action through the sensory nerves.

How the blood supply is affected has already been seen.

The muscular fibres are directly irritated, and so stimulated to action, by being well kneaded when the bundles of fibres become rubbed against one another.

Irritation of the nerve to a muscle will cause its fibres to be stimulated, or to contract according to the pressure used. Too great an irritation, as very firm pressure on the nerve, causes a temporary paralysis. The reflex action of the motor nerve through the sensory nerves and spinal nerve centres is well known as in tickling the soles of the feet, &c.

Nervous System.—The sensory nerves are affected qualitatively by Massage; for instance, itching on friction becomes burning, as is seen in various cases of Pruritus. Friction also causes a sensation of warmth in a part which originally felt cold. Massage allays pain. When a child is whipped it rubs the painful spot. Again in

intense pain, as in neuralgia, pressure on the nerve gives temporary, sometimes permanent relief.

To sum up shortly, Massage has the following effects :—

1. To increase or diminish the blood supply of a part.
2. To increase the local nutrition.
3. To transform or absorb morbid products.
4. To increase the reflex actions towards a part.
5. To allay or modify pain.
6. To stimulate the muscles.

The following are the various manipulations comprised under the term Massage. The description and mode of application in each will be taken separately, stroking, sawing, fulling, kneading, vibrating, chopping, pointing, clapping, knocking, and pressure.

Stroking.—There are two kinds of stroking, light and heavy. In light stroking, the hand or hands are moved without any particular pressure over the patients uncovered skin, whilst in heavy stroking, more pressure is exerted on the parts. Stroking is performed in a direction either towards or away from the heart, according to the effect desired. Stroking of the limbs against the venous current is done in a longitudinal direction from the trunk towards the extremity of the limb, this constitutes stroking against the valves of the veins. The operator's fingers are either flat or slightly bent, and partly grasp and surround the limb. Stroking in a reverse manner from the fingers or toes towards the trunk is termed stroking "with" the valves.

Head Stroking.—Both hands, the fingers of which are a little spread and directed upwards, are placed one on the neck, the other on the forehead, and moved simultaneously upwards towards the crown of the head.

Back Stroking.—The hands work alternately, stroking very strongly down the middle of the back from the neck to the sacrum.

Alternate Abdomen Stroking.—Here the operator standing in front of the patient, who may be leaning against a wall or in a semi-recline position on a couch, moves his hands alternately from the "linea alba" in a straight direction outwards.

Concentric Abdomen Stroking.—The palms of the hands are moved in large or smaller circular lines over the whole surface of the abdomen, more or less pressure being used.

Colon Stroking.—The hands are placed parallel to each other, with their ulnar edge against the anterior surface of the pelvis and pressed deep into the abdomen, the left hand passes upwards near the edge of the right hip-

bone, and then across the abdomen, while the right hand simultaneously descends down and inwards towards the pubes.

Sawing.—The ulnar side of the hand is moved like a saw, progressing slowly sideways over all parts to be acted upon.

Fulling.—The palms of the hands are placed on opposite sides of the part to be operated on, one of the hands is then slid forward, whilst the other slides backwards and so on, slowly down the part, just as one rolls out a piece of putty or clay between the hands.

Skin Fulling.—A large wrinkle of the patient's skin is taken hold of by the fingers of both hands, which then move to and fro, so that the fold of skin is moved simultaneously in opposite directions.

Abdominal Fulling is done by an alternate movement of both hands, placed transversely, the ulnar edge of one pressing down whilst the other is raised.

Kneading.—This is performed in a similar manner as in kneading dough.

Peristaltic Kneading of the Abdomen.—The operator stands behind the patient, who leans forward with the abdomen well relaxed. The fingers are slightly bent, and move with a vermicular kind of motion, up and down and sideways, all over the abdomen.

Vibration.—The hands or fingers whilst vibrating are placed on various parts of the patient, and so communicate their vibration.

Head Vibration.—The head is grasped by placing one hand on the forehead, the other on the back of the head, and then vibrated.

Nose Vibration.—The fingers of one hand are placed on both sides of the root of the nose, and are then vibrated.

Larynx Vibration is done in a similar manner as in nose vibration.

Chopping, Pointing, Clapping, and Knocking, are various kinds of percussion, made very quickly one after another. To do these manipulations properly, one requires much practice, and must have the wrist joint very flexible, so that a true vibrating movement may be produced and not merely a dead blow. The patient should not feel any pain, not even after knocking with the fist, but rather an agreeable sensation of warmth and liveliness.

Chopping is a kind of percussion made with the ulnar edges of both hands, which move alternately up and down from the wrist joint.

Pointing is used over bony parts, it is a light percussion and is done by the tips of the fingers as in striking the keys of a pianoforte.

Clapping—The flat of the hands is used in an alternate manner as in chopping.

Knocking is a firm percussion performed with the front of the closed fist.

It is needless to say that all the above manipulations require a great deal of practice. In their application they should never give rise to pain, but always alleviate it.

I find some difficulty in reporting cases treated purely by Massage, for the reason that I use it as a part of a medical gymnastic treatment. Miss G. who had old lateral curvature due to muscular debility, used to complain of very severe pains in the back after any exertion, also at night time. These pains were very soon relieved by longitudinal stroking down the back on either side of the spine, and by light chopping over the painful part. This patient besides, had club foot, the feet were always cold, also very painful after walking. By kneading and fulling the limbs from the thighs towards the toes, the pains subsided, and the parts became red and warm. After pursuing this treatment for six weeks, she was able to go out walking and shopping with very little trouble.

For so-called rheumatic pains and tired muscles Massage is invaluable in its action generally, giving permanent relief. In these cases I clap, chop, and stroke the painful part; the treatment in the beginning must be gently applied, but after a few minutes the patient is able to bear a pretty hard application.

Neuralgic Headache.—Gentle chopping, pointing, and stroking of the head where the pain is severe, cause a soothing effect, giving an inclination to sleep. It is curious to watch the patient whilst undergoing this manipulation, how they slowly close the eyes, all appearance of suffering gradually disappearing.

Flatulence can be relieved by firm stroking and kneading of the abdomen, and by knocking with the front of the closed fist over the sacrum. I have found this of great benefit in the flatulence of pregnancy.

Gripping Pains are soon relieved, as follows:—The patient stands in a stooping position, with the operator behind, who, with closed fists, kneads firmly all over the relaxed abdomen.

Neuralgia can sometimes be relieved by firm pressure, *e.g.*, by pressing the thumbs firmly over the painful spot.

Constipation.—In the March number of this *Gazette* is published the treatment of Habitual Constipation.

Palpitation of the Heart.—I have relieved this, especially when due to nervousness, by tapping the fingers over the region of the heart.

Over-distended Breasts are very soon relieved by gentle friction. The secretion of milk can be excited by rubbing the nipples.

Pannus.—In mild forms concentric friction over the closed eyelid are of great use in promoting the absorption of the morbid corneal vessels.

Pruritus Ani and pain after a difficult evacuation is soon relieved by vibrating and chopping the part.

Varicose Veins are benefited by stroking in a direction towards the heart.

In conclusion, I may add that Massage combined with medical gymnastics, will be found of great use as a curative agent; but it must not be over estimated, it gives great benefit in suitable cases but not otherwise.

MEDICAL APPOINTMENTS.

- Courtenay, John Hoysted, M.K.Q.C.P., Irel., L.R.C.S., Irel., to be Health Officer for Rochester, Vic.
- Cushny, William Alexander, M.D., to be Public Vaccinator for the Cambridge district (prov. Auckland), N.Z.
- Degner, Charles Henry, M.D., to be Health Officer for the shire of Wimmera (West Riding), Vic.
- Dickinson, George Dixon, M.R.C.S.E., M.B. et Ch.M., Edin., to be Health Officer for shire of Bulla, Vic.
- Dyson, Thomas Sheppard, M.R.C.S.E., to be Govt. Medical and Health Officer at Normanton, Qu.
- Fulford, John, M.R.C.S.E., L.R.C.P., Edin., to be Public Vaccinator for the district of Dunkeld, Vic.
- Gürger, Oscar, M.D., elected Honorary Surgeon to the Adelaide Hospital.
- Grady, John Fitzgerald, M.D., appointed Medical Officer to the Hill End Hospital, N.S.W.
- Gray, John, M.R.C.S.E., to be Public Vaccinator at Avenel, Vic.
- Jee, Henry Christian, M.R.C.S.E., L.R.C.P., Edin., to be Public Vaccinator at Mount Wycheproof, Vic.
- Johnston, William, Ch.M., Glasg., to be Health Officer for shire of Portland, East and West Ridings, Vic.
- King, Thomas Radford, M.D., to be Certifying Officer under the Public Health Act, for the Vaccination Districts of Greymouth, Hokitika, Jackson's Bay, Kumara, Okarito, Ross, and Waima, N.Z.
- Macintyre, John Henry Lee, M.R.C.S.E., to be an additional Public Vaccinator for the Palmerston North district, N.Z.
- M'Murray, Wahab, M.D. et Ch.M., Qu. Univ., Irel., elected Medical Officer to the Walgett Hospital, N.S.W.
- Marchbank, John, M.B. et Ch.M., Edin., to be Public Vaccinator at Terang, Vic.
- Matheson, Henry Alexander Rigby, L.R.C.P., Edin., L.F.P.S., Glasg., appointed House Surgeon to the Launceston General Hospital, vice Dr. L. G. Thompson, resigned.
- Phillips, John Walter, M.B., Melb., L.R.C.S., Edin., to be Public Vaccinator for West Melbourne, Vic., vice F. Workman, M.R.C.S.E., removed.
- Phippe, John Blakemore, M.D., M.R.C.S.E., to be Health Officer for the shire of Romsey, Vic.
- Soulé, Milan, M.D., to be Assistant Health Officer at Townsville, Qu.
- Swanston, Charles, L.R.C.P. et R.C.S., Edin., to be Acting Visiting Surgeon to the Mudgee Gaol, N.S.W.
- Turner, Duncan, L.R.C.P., Lond., L.R.C.S. Edin., to be Health Officer for shire of Bulla, Vic.
- Westrum, Richard, M.D., Munic., elected Resident Medical Officer at the Sydney Hospital.
- Wray, Charles James Hill, L.R.C.P. et R.C.S., Edin., appointed Secretary to the Queensland Central Board of Health.

THE MONTH.

NEW SOUTH WALES.

A FRESH case of Smallpox was discovered at Riley Street, Woolloomooloo, on Saturday morning, Nov. 1. The usual precautionary measures were adopted as speedily as possible, and the patient and a number of persons with whom she had come in contact were removed to the Quarantine Station at North Head.

THE case instituted by the Board of Health against Dr. Eichler for the supposed neglect of not reporting the recent case of Smallpox at the Orient Hotel, in George Street, was concluded at the Water Police Court, Sydney, on October 23. Dr. Eichler, in consequence of the great expense and trouble he had gone to, withdrew his plea of not guilty, and made the following statement:—"Although I believe that the case for which I am prosecuted was a case of varicella, in English called Chickenpox, still, if it should be proved to be a case of variola, or Smallpox, it could only have been an error of judgment, which error is daily made and confessed to by the most eminent medical men all over the world, and is therefore not punishable. It was no case of secrecy or of avoiding the laws of the country, but could only have been an error of judgment on my part. Besides, it is well known that Chickenpox and Smallpox appear on the same individual, or attack others in the same locality, at the same time. Also, it is an established fact that Chickenpox is a forerunner of Smallpox. Sir Erasmus Wilson says: 'In modified variola there is a wide range of variety, sometimes verging on variola, sometimes on varicella, which has given rise to considerable perplexity and has been the occasion of attaching the term varicella to many forms of the eruption which in reality appertain to variola, and notwithstanding all medical skill and care we shall find the question of diagnosis in these cases most difficult and obscure.'" The presiding Magistrate then said that in view of the fact that the defendant had pleaded guilty and the prosecution had only asked for the minimum penalty, he would therefore impose a fine of £10 with £5 ss. costs.

At the last meeting of the Board of Directors of the Sydney Hospital, a letter was received from Dr. Brady, honorary surgeon of the institution, asking for 12 months' leave of absence, on the ground that he was about to visit Europe. It was resolved that the letter should be accepted as a resignation, and that steps should be taken to appoint another medical gentleman to the position.

At a recent meeting of the Lismore Hospital Committee it was resolved to apply to the Government for a special grant of £500, on the ground that this institution had hitherto been neglected.

THE outbreak of scarlet fever at Barmedman has assumed such a serious aspect, that the Medical Adviser to the Government has despatched a medical officer and two trained nurses to the place.

WE understand, that since Dr. Fiaschi's departure from Windsor, the number of patients in the Hawkesbury Hospital has decreased considerably.

DR. R. J. ALLAN, a new arrival, has settled at Raymond Terrace, at the junction of the Hunter and Williams River, 92 miles N.E. of Sydney.

MR. JOHN MASON BOOTH, L.R.C.S., Irel., 1860, late Surgeon in the N. S. Wales Immigration Service, died at Sydney on October 18, at the age of 54.

DR. A. J. BRADY, of Hyde Park, Sydney, has left for London and the Continent of Europe, and intends to stay away for about twelve months. Dr. Ph. E. Muskett, late in the N.S.W. Immigration Service, and formerly Resident Surgeon at the Sydney Hospital, will carry on Dr. Brady's practice during his absence.

DR. D. COLLINGWOOD, late Senior Demonstrator of Anatomy, and Demonstrator of Practical Surgery at University College, London, has commenced practice at Summerhill, a suburb of Sydney.

DR. H. M. C. DALTON, a new arrival, has commenced practice at Newcastle, in conjunction with his brother-in-law, Dr. John Harris.

DR. W. M'MURRAY, a recent arrival, has commenced practice at Walgett, the centre of a pastoral district, 450 miles N.W. of Sydney.

MR. CHARLES EDWARD HERON ROGERS, L.R.C.P., Lond., 1868, [M. et L. Mid. R.C.S., Eng., 1864, L.S.A., Lond., 1865, whilst travelling as medical referee for the Equitable Insurance Company, died suddenly from serous apoplexy at Mudgee, on October 23.

NEW ZEALAND.

DR. A. J. LEGGATT, of Gisborne, has resigned his commission as Honorary Surgeon in the N.Z. Volunteer Force.

DR. J. MOUNTAINE, of Te Pahi, has removed to Waipu, a post town 67 miles N. of Auckland.

DR. W. R. PEARLESS, late of Tarraville (Vic.), is now practising at Wakefield, Prov. Nelson.

QUEENSLAND.

A QUARANTINE station is to be erected at Magnetic Island, Townsville.

DR. T. S. DYSON, formerly surgeon in the British India Company's service, has settled at Normanton, the port of an extensive gold and copper-mining district, 50 miles from the Gulf of Carpentaria.

DR. JAS. HILL, late Assistant Physician to St. John's Hospital for Skin Diseases, London, and Clinical Assistant to the Central London Throat and Ear Hospital, has commenced practice at "Fern View," Alice-street, Brisbane.

DR. E. M. OWENS, late of the Midland Eye Hospital, and Hospital for Diseases of Women, has commenced practice at Brisbane as a specialist for diseases of the eye and diseases of women.

SOUTH AUSTRALIA.

THE admissions into the Adelaide Children's Hospital during the year ending September 30, 1884, numbered 228, being an increase of 48 cases over last year. 222 patients were discharged, and of these 134 were cured, 65 improved, and 23 unrelieved. The number of deaths was 15. The principal diseases treated were as follows: Enteric fever, 33; hip disease, 30; eye diseases, 29; spinal diseases, 15; bronchitis, 11; injury, 11; eczema, 10, &c., &c. At the Out-patients' Dispensary, which was removed from Currie-street to North Adelaide, in November last, 2,444 cases have been treated during the same period, as against 2,647 during the previous twelve-months.

No fewer than 25 cases of an infectious nature, principally measles, broke out in the Adelaide Children's Hospital during the twelve months ending September last.

A COURSE of lectures on subjects embracing anatomy, physiology, and hygiene has recently been delivered at the Adelaide Children's Hospital to the nursing staff by the following members of the medical profession, viz.:—Drs. Campbell, Cleland, Curtis, Jay, Nesbitt, and Wigg. As on previous occasions, these lectures were open to the public, and judging from the large attendances, were much appreciated. A second course of lectures has been arranged to be given this month, and will doubtless prove as interesting and instructive as those already delivered.

DR. J. W. CHOWN, late Honorary Surgeon to the Jamestown Hospital, is dead.

DR. J. G. JEFFREYS, formerly Resident Obstetrician at St. Thomas's Hospital, London, and Resident Medical Officer at the Fisherton Asylum, Salisbury, has commenced practice at Gawler, the centre of a large wheat-growing district, 26 miles N.E. of Adelaide.

DR. J. A. C. WELCHMAN, of Glensielg, has removed to Clarendon, in an agricultural district, 18 miles S.E. of Adelaide.

DR. H. H. WIGG has settled at Unley, a suburb of Adelaide, and Dr. C. G. D. Morier at Morphett Vale; both gentlemen are new arrivals in the colony.

VICTORIA.

AT a meeting of the University Council, held on November 4, Drs. J. P. Ryan and Springthorpe were unanimously appointed examiners in surgery and pathology respectively, in the room of Mr. Fitzgerald and Professor Halford, the former being absent from the colony, whilst the latter desired to be relieved. It was decided to ask Mr. C. R. Blackett to take the place vacated by Mr. Newbery as examiner in chemistry. Dr. Fulton was appointed co-examiner in medicine in the place of Dr. Robertson, resigned. The council unanimously refused to sanction a recommendation from the medical faculty that attendance at a recognised hospital as in-dresser should be counted as attendance at University lectures. The present lecturers were reappointed for 1885, with the exception of the clinical lecturer, whose appointment was held over until the report of a committee, appointed to confer with the hospital authorities, was received by the council.

A MEETING of the Faculty of Medicine of the Melbourne University was held on Wednesday afternoon, October 29. The following gentlemen were present:—Professor Allen, Mr. Girdlestone, Dr. Jamieson, and Dr. Williams. The following letter from 22 medical students was considered:—

"October 14, 1884.

"To the Dean of the Faculty of Medicine.

"Sir,—We, the undersigned medical students attending lectures at the Melbourne University, wish to respectfully draw attention to the following points in which our surgical education seems susceptible of improvement:—1. No regular clinical instruction, as lately provided for by the council, is given in the wards consequently the students for whose benefit bedside instruction was established have, in a great measure, ceased to accompany the lecturer on his rounds. 2. We receive little or no instruction in therapeutics. 3. Consultations as at present conducted are useless to us as a means of education. Most of the operations are performed at from 2 to 3 p.m., at which hour we are present at lectures; attendance on an operation may cause us to lose a valuable demonstration. 5. In many cases the operator gives no information as to the

nature of the injury or disease demanding operation. 6. Owing to the present method of recording attendances at the hospital, no credit for attendance is given unless we go to our own particular wards; consequently we are unable to give due attention to the out patients' department, where many instructive cases are to be seen."

After some discussion it was resolved that clause 1 of the preceding letter should be referred to Mr. Girdlestone, and the remaining clauses referred to a committee of the Faculty of Medicine already appointed to revise the medical course.

At a meeting of the University Council, held on October 20, the report from the Faculty of Medicine in reference to certain charges formulated by Drs. Balls-Headley and Rowan against Dr. Jamieson, the lecturer on obstetric medicine and the diseases of women and children, was adopted so far as it related to the exoneration of Dr. Jamieson.

THE Lunacy Commission held a sitting at Kew Asylum on October 23, when evidence was given of gross mismanagement. One of the warders stated that the control of the Asylum was left in the hands of the head warder. He also spoke of the ill-treatment of patients by some other officers, the neglect of their duties, and bad provisioning. Mr. Blackett, a member of the commission, stated that he had analysed a sample of the coffee, and it was the most villainous compound ever sold in Australia. Some of the patients were also examined, and corroborated the evidence as to ill-treatment by warders.

WHOOPING COUGH is very prevalent at Rupanyup, and the state school is closed in consequence. Several adults are also suffering from the complaint.

MR. THOMAS PROUT WEBB, Barrister-at-Law, has been appointed Master-in-Lunacy, vice Mr. F. Wilkinson, resigned.

PUBLICATIONS RECEIVED.

Some Affections of the Nervous System in which the Syrup of Hypophosphites (Fellows') is beneficial. New York: Jas. I. Fellows, 1883.

Some conditions of Infancy and Childhood, in which the Syrup of Hypophosphites (Fellows') is beneficial. New York: Jas. I. Fellows, 1884.

Notes on the Surgical Treatment of Hæmaturia and Rupture of the Bladder. By Reginald Harrison, F.R.C.S., Surgeon to the Liverpool Royal Infirmary, Edinburgh: Neill & Co., 1884.

On the Treatment of certain cases of Prostatic Obstruction by a Section of the Gland. By Reginald Harrison, F.R.C.S. Liverpool: D. Marples & Co., 1884.

On some important points connected with the Surgery of the Urinary Organs. By Sir Henry Thompson, F.R.C.S., M.B., Lond., Professor of Surgery and Pathology to the Royal College of Surgeons. London: J. & A. Churchill, 1884.

Eighth Annual Report of the Board of Management of the Adelaide Children's Hospital, for the year ending September 30, 1884.

Annual Report of the Board of Regents of the Smithsonian Institution, showing the Operations, Expenditures, and Conditions of the Institution for the years 1880 and 1881; also List of Foreign Correspondents, corrected to January, 1882. 3 vols. Washington: Government Printing Office.

REPORTS OF SOCIETIES.

MEDICAL SOCIETY OF VICTORIA.

THE ordinary monthly meeting of the above Society was held in the Hall of the Society, Albert-street, East Melbourne, on Wednesday, November 5th, the President, Dr. Haig, in the chair.

Mr. Girdlestone related a case of empyema in which paracentesis was successfully employed. The patient was exhibited.

Dr. Webb also exhibited a patient upon whom he had operated for a like lesion.

Dr. Snowball exhibited the tail of a child which he had excised, and related the case.

Professor Allen exhibited a number of pathological preparations.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Read, Henry, L.R.C.P., Edin., 1883; L.F.P.S. Glasg., 1883.

Murphy, Michael Dominick, L.F.P.S., Glasg., 1868; L.S.A., Lond., 1868.

Andrews, Thomas Morgan, L.R.C.P., Edin., 1879; L.F.P.S., Glasg., 1879.

Eddie, Arthur William, M.B. et M.Ch., Aberd., 1882.

Partridge, William Stroud, L.S.A., Lond., 1881.

Devia, Charles, L.S.A., Lond., 1877; M.R.C.S., Eng., 1877.

Parry, Lloyd Davenport, L.R.C.S., Edin., 1871.

Schwarzbach, Bruno Behelm, L.F.P.S., Glasg., 1880.

Anderson, Eugene Wilton, M.B., Melb., 1881; L.R.C.S. et R.C.P., Edin., 1883.

M'Murray, Wahab, M.D. et Ch.M., Queen's Univ., Irel., 1881.

Jack, Robert Nelson, L.R.C.P. et R.C.S., Edin., 1878.

Whitworth, Edward, L.R.C.P., Edin., 1875; M.R.C.S., Eng., 1874.

Irving, Duncan Bell, M.R.C.S., Eng., 1883; L.R.C.P., Lond., 1883.

NEW ZEALAND.

Bulleid, Edgar George, L.R.C.P. et R.C.S., Edin., 1883.

TASMANIA.

Butler, Gilbert Edward, M.R.C.S., Eng., 1882; L.R.C.P., Lond., 1884.

VISUAL TROUBLES DUE TO THE ABUSE OF TOBACCO. Galezowski (*Recueil d'ophtalmologie*, November, 1883) returns to the charge in a short paper. The nicotine intoxication generally produces no organic alteration in the eye, and the only perceptible ophthalmoscopic sign is a simple paleness of the pupilla, due to spasm of the blood-vessels. If, however, the disease is prolonged indefinitely, there are produced certain degenerative changes in the optic-nerve fibres, and finally an atrophy of the pupilla. The most characteristic signs of nicotine amblyopia are: myosis, diminution of visual acuity, central scotoma sometimes extending far towards the periphery, which may lead to complete blindness, more or less prolonged, chromatic scotoma, chromatic phenomena, and chromopsia.—*N. Y. Med. Journ.*

CORRESPONDENCE.

FEES TO MEDICAL WITNESSES.

(To the Editor of the A. M. G.)

DEAR SIR,—About a fortnight ago I was requested by the police to examine a woman for alleged rape, but I refused to do so unless I was guaranteed a sum of £10 10s.

The police telegraphed to the Under Secretary for Justice as to how they were to act in the matter. I do not know what reply they received, but I know that the accused was acquitted without any medical man examining prosecutrix. Now, Sir, was I justified in demanding such a fee? And if so, will the Government guarantee it? According to the code of fees published in the *Australasian Medical Directory*, an opinion, involving a question of law, is set down at £10 10s. Had I examined this woman first and demanded a fee of £10 10s. before I gave evidence, I would probably be told that my proper fee was £1 1s., and unless I gave evidence for that amount steps would be taken to make me do so. Now as this question affects the whole Medical Profession, I would willingly have their advice for future emergencies.

I remain, Dear Sir, Yours truly,

A. A. JOHNSTON, M.K.Q.C.P.I., L.R.C.S., Ed.
Parkes, October 13th, 1884.

[We think our correspondent acted properly in making the demand he did; for a less sum than £10 10s. would be totally inadequate remuneration for such an examination, leading as it probably might to attendance at a Police Court, again at the Quarter Sessions or Circuit Court, with all the vexation, worry, loss of time, expenditure of labour and thought, which falls on a medical man called as an expert witness. We intend to write further on this matter in a future issue.—*Ed. A. M. G.*]

AMERICAN DIPLOMAS AND THE N.S.W. MEDICAL BOARD.

(To the Editor of the A.M.G.)

Sir,—In your October Number a letter appears from a gentleman possessing the M.D. degree of the University of Philadelphia, complaining that the N.S.W. Medical Board will not allow him to register. Possibly the Medical Board may have read the correspondence which appeared in the *Lancet* of August 23rd, which I enclose. The British Consul at Philadelphia and your correspondent, the candidate for registration, appear to hold somewhat different views with regard to the value of the degree.

I am, &c.,
M. B.

Nov. 12, 1884.

"BOGUS AMERICAN DEGREES."

(To the Editor of THE LANCET.)

Sir,—I notice in your issue of August 16th, an extract from *The Times* about the bogus M.D. of the University of Philadelphia. In this district and in the North of England generally, where collieries and ironworks exist, there the impostors of Philadelphia plant them-

selves, and are a curse to the unfortunate working class, whom they dupe.

I send you the original letter I received from the British Consul at Philadelphia. Will you endeavour to bring it under the notice of the medical men in Parliament? Something ought to be done to stop this quackery.

I am, Sir, yours truly,
JOHN C. O'HANLAN.

Tudhoe Grange, Spennymoor, Durham, Aug. 16th, 1884.

"British Consulate, Philadelphia, July 26th, 1884.

"Sir,—With reference to your letter of the 25th ult., I have to inform you that the University of Philadelphia is no longer in existence, its charter having been cancelled by the Government of Pennsylvania after a disgraceful existence of many years. *Diplomas purporting to issue from such an institution are bogus and a fraud upon the community.*

"Your obedient servant,

"ROBERT CHARLES CLIPPERTON,
Her Majesty's Consul.

"John C. O'Hanlan, Esq., M.D.,
Tudhoe Grange, Spennymoor, Durham."

THE LUNACY LAW IN QUEENSLAND.

(To the Editor of the A. M. G.)

Sir,—Would you kindly inform me through your paper whether the provision making it illegal for two Medical men being partners, or the assistant to the one or other, together to sign a certificate of admission for a lunatic patient into a Lunatic Asylum, holds good in Queensland, as it does in the other colonies.

If it holds good what is the penalty for breaking that law by the Medical Practitioner, the position of the friends of patient in such a case, and their remedy, if any exists; also the position of the Medical Practitioner so offending?

Yours truly,
S. HAMMOND, L.R.C.P., etc.

Townsville, Qu., October, 1884.

[According to the Queensland Insanity Act of 1884, assented to on the 2nd September last, no Medical Practitioner whose partner or assistant has signed the order or request, or one of the certificates, for the reception of any person as a patient into an asylum shall sign any certificate for the reception of the same person, if he does so his certificate will not be valid, and therefore the patient cannot be received into any Asylum on the strength of it. There is no penalty provided for any Medical Practitioner signing a certificate under such circumstances as stated by our correspondent, and as such a certificate would be of no consequence, the friends of the patient could bring no action against the Practitioner signing it; but the superintendent or any person who knowingly receives a patient into an Asylum on the production to him of such an improper document would be guilty of a misdemeanour. We may add that in cases where it is impracticable to obtain the certificates of two independent practitioners, a person may be received into a reception-house upon the certificate of one Medical Practitioner alone, but in every such case one other certificate signed after such person was received into the reception-house, shall before his removal to an Asylum, be produced to or lodged with the superintendent of the Asylum.—*Ed. A.M.G.*]

REPORTED MORTALITY FOR THE MONTH OF SEPTEMBER, 1884.

Cities and Districts.	†Population.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from							
				Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Child-bearing.
N. S. WALES.											
Sydney	103,379	212	65	...	2	3	4	5	6	21	3
Suburbs	120,832	240	104	...	3	4	9	7	9	22	3
NEW ZEALAND.											
Auckland	27,822	34	15	...	...	1	3	2	...	6	...
Christchurch.....	16,277	19	6	...	...	...	1	...	...	3	...
Dunedin	26,082	26	7	...	...	2	...	...	...	3	1
Wellington	22,585	31	15	...	...	2	...	...	1	4	...
QUEENSLAND.											
Brisbane	26,557	51	25	*	...	...	...	...	...	...	...
Suburbs	9,612	28	8	...	...	...	...	...	...	...	...
SOUTH AUSTRALIA.....	315,834	313	121	6	...	12	2	4	5	33	...
Adelaide	42,605	65	17	...	...	1	...	1	1	9	...
TASMANIA.											
Hobart	28,333	34	11	1	1	2	...	1	...	8	1
Launceston.....	17,840	24	12	...	...	1	...	...	...	2	...
Hospitals, Asylums, Gaols, &c. .	1,205	20	...	...	...	...	...	...	...	...	...
Country Districts.....	80,739	72	...	...	...	4	1	2	...	...	..
VICTORIA.											
Melbourne	65,791	82	171	34	1	9	17	9	1	69	13
Suburbs	238,618	438									

* The Official Monthly Report on the Vital Statistics of Brisbane and Suburbs does not show the number of deaths from the various diseases.
† The population of N. S. Wales, Queensland, and Adelaide is that of the census of 1881; New Zealand, South Australia, Tasmania and Victoria show the estimated population at the present date.

BELLADONNA INJECTION FOR GONORRHOEA, John Roche, M.D.—Some 13 years ago an officer on board one of the vessels of the Indus Steam Flotilla consulted me for a bad gonorrhoea with intense pain on micturition, and intolerable chordee at night. The case was urgent and I ordered an injection composed of seven ounces of water, an ounce of mucilage acacia, 20 grains extract belladonna, and 20 grains sulphate zinc, a teaspoonful to be injected immediately before and after micturating, and a similar amount the last thing at night, great care to be used in passing the injection fully down as far as the pain was most intense. An ointment of spermaceti and mercurial ointment, four drachms each, and ten grains extract belladonna, ten grains powdered opium, a paste to be smeared along the perineum and around the crura penis at night. Patient left next morning, having had no chordee that night, and the pain of micturition disappeared by using the injection. Within a week there was complete cure.

From that time I have had numerous gonorrhoeal cases of every type and stage, and I have used the injection in every instance, and without exception, with unflinching success. Not long since a shop assistant presented himself with a bad gonorrhoea, high fever, inflamed testicle, and chordee at night. With the application of the belladonna and opium ointment the chordee did not appear, and in four days after using the injection the running ceased, but after the first application the pain and running were much lessened. A suspensory bandage was worn, and with the daily use of the mercurial and belladonna and opium ointment the patient was quite well in less than three weeks. Patients have always stated that it is the injection and not the ointment which stopped the chordee carminatively. I have tried the anodyne treatment in various classes of people, from the dissipated nymphs of the Eastern bazaars to the well fed *roués* in the West; in the acute and in the chronic and gleet stages; in first attacks and in those making one of a series; and in cases complicated with inflamed testicles and chordee; and I have no hesitation in saying that, I have not witnessed anything to contraindicate it, nor to mitigate its success.—*Med. Press.*

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

CASE OF SUPRA-VAGINAL AMPUTATION OF THE UTERUS.—RECOVERY.

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IN reporting some cases of successful operation to the Obstetrical Society of London in 1880, Mr. Knowsley Thornton expressed it as his opinion, that the removal of uterine fibroids by laparotomy was not only justifiable, but was an operation with a position in the immediate future in no way second to that now held by ovariectomy. Those who have followed the progress and development of abdominal surgery in this direction will, I think, be inclined to admit that there is at least a reasonable prospect that Mr. Thornton's prediction will be fulfilled; but whether this will be the result or not, I think there can be no doubt that the cases included in the above category, are of sufficient gravity and infrequency to deserve record.

If any further plea for the present report be necessary, I submit that, as far as I know, it is the record of the first successful case of removal of the uterus by abdominal incision in South Australia, and one of the very few successful cases of a similar character that can be found in the somewhat scanty surgical literature of the Australasian colonies.

A. D——, a domestic servant, aged 26, was admitted to the Hope Ward of the Adelaide Hospital, under the care of Dr. Thomas, on the 1st January, 1884. She had very recently arrived from England, and at first stated that she was unmarried, though she confessed to afterwards being a widow, and to having had one child in the old country eight years ago. Dr. Dunlop's notes of her condition on admission are as follows:—She

has felt ill for the last seven months, and now complains of extreme weakness with repeated profuse hæmorrhage from the vagina. Menstruation, formerly regular, ceased during her voyage from England with one exception, when the discharge was very profuse. During the last seven months, the period of her residence in South Australia, menstruation has taken place every month in profuse quantities on each occasion. She is now very weak and anæmic, and is at the time of admission losing a considerable quantity of blood. Examination per vaginam showed the vagina to be roomy, with the os uteri transverse, slightly split at the left side, and looking downwards and backwards the sound passes easily anteriorly for 5½ inches, and returns clean. Abdominally, a large hard, apparently solid tumour can be easily felt, reaching to about the level of the umbilicus. It moves with movements of the cervix, and any movement of the tumour is easily communicated to the cervix, and to the sound within the uterus. No differentiation between tumour and uterus can be made out. A diagnosis of fibroid tumour of the uterus was made, and she was ordered moderate doses of liquid extract of ergot with liquor opii sed. every three hours. The quantity of liquid extract of ergot was subsequently increased, and then replaced by ergotin.

Under this treatment, with the addition of quinine, she made slight but definite improvement which was interrupted on the 24th January by a moderately severe attack of tonsillitis, during which the temperature rose to 105·6°. This subsided in the course of a few days, and on the 18th April she was sent to the Convalescent Hospital, with instructions to return in a fortnight for further treatment.

After she had been a week at the Convalescent Home, she was persuaded to consult a man who professed to heal by the laying on of hands, and she was of opinion that a cure had been wrought by the process. However, two days after leaving the Home, the hæmorrhage recurred so profusely, that she again sought re-admission to the Adelaide Hospital on the 14th May, 1884. She was then found to be in a much worse condition than at the time of her first admission—and the tumour was very perceptibly larger. Treatment by ergot, ergotin, and morphia in succession was again tried, without producing any improvement, and on the 10th July she was transferred to my care for some operative interference.

After careful examination by myself and colleagues, and on consultation between us, it was decided that the case was one in which it was proper either to endeavour to check the hæmorrhage by removing the ovaries and appendages, or, if on examination it appeared feasible, to remove the tumour with, if necessary, the uterus as well.

The nature of the operation, with the risks attendant upon it having been explained to her, she decided without any hesitation to place herself unreservedly in our hands. On three several occasions the day for the operation was fixed, but was unable to be proceeded with, owing to the unexpected access of profuse hæmorrhage just before hand. Eventually, during a complete remission of the bleeding, abdominal section was performed in the ovariectomy cottage, on the 4th August. The patient having been prepared in all respects as for ovariectomy, ether was administered, and the operation performed under all antiseptic precautions, including the carbolic spray placed at a distance of about 12 feet, but not allowed to play upon the wound. A median incision, about 4 inches long, was made in the first instance between the pubes and umbilicus, so as to admit the hand for exploration, which showed uterus and tumour incorporated indistinguishable from one another, and together forming a rounded tumour about the size of a child's head at full term. Examination of the appendages showed one ovary to be studded with small cysts, and my colleagues agreed with me that the whole uterus, with these appendages, should be removed. The incision was then extended downwards to the pubic symphysis, and upwards to about an inch and a half above the umbilicus, being now from 10 to 11 inches in extent. One trifling adhesion only of the omentum was met with, which was tied and divided. The broad ligaments on each side were transfixed with a blunt needle on a handle armed with thick Chinese silk, and tied in two portions, an additional ligature being placed on each portion for security. Uterus and tumour could then without difficulty be brought out of the wound. The thick pedicle formed by the neck of the uterus was then at a point about an inch above the os, surrounded by a thick silvered copper wire, the ends of which were attached to a Kœberle's *serre naud*, with which the wire was gradually tightened. The first wire thus applied broke under the strain, but the second held securely, and with the *serre naud* attached, inferiorly, was left in position. The tumour, which was an interstitial fibro-myoma, was then rapidly removed by successive slices, down to within an inch and a half of the wire. In this performance, after the

first gush of contained blood, there was no bleeding whatever, it being completely restrained by the wire clamp. In spite of the size of the wound there was no protrusion of the intestines throughout the operation, these being most carefully protected and retained by napkins wrung out in hot water. After sponging out the abdominal cavity, the pedicle, with its attached *serre-neud*, was then brought out of the incision as low down as possible, and the wound closed in the ordinary way with about 20 sutures of Chinese silk, thick and thin, the greatest care being taken to close the parts as securely as possible round the pedicle. The surface of the stump was painted with 100 per cent. solution of chloride of zinc, and the surface and sides backed with cotton wool soaked in a 3 per cent. solution of the same material and dried. The whole wound, including the stump, was then dressed according to Lister's method, and a wide flannel binder placed over all. The whole operation occupied about two hours. Before recovering consciousness, a hypodermic injection of half a grain of morphia was administered.

I will not weary you by any detailed notes of the progress of this case, which have necessarily extended over a considerable period. As the course was throughout favourable and uninterrupted by any serious complication, I am fortunately able to briefly summarise them as follows :—

A very favourable re-action followed the operation, she remained almost completely free from pain, had no vomiting, and under the influence of morphia injections repeated when necessary, slept quietly the greater part of the night. Nothing was given by the mouth for the first 24 hours, except a little ice. Throughout the next day (5th August) she remained quiet, comfortable, and free from pain or sickness, being mostly under the influence of morphia. Skin moist and cool. Tongue clean and moist. Pulse good, varying from 112 to 120. Towards the afternoon she complained of being very hungry, and was ordered two ounces of chicken broth in teaspoonful doses, with similar quantities of brandy occasionally. Morphia injections were as heretofore given when necessary, and the urine drawn off at stated times, which on the first occasions for some time was very thick and high-coloured, containing copious lithates.

She passed another good night, sleeping well, and the following day (6th August) found her still in a very favourable condition, though complaining a little of pain, flatulence, and hunger. The wound was dressed under ether and spray, in the same manner as at first. Everything was sweet, and the clamp holding so well that it was

not found necessary to tighten it. She was now ordered fixed but small quantities of chicken broth, milk, soda water, and brandy daily. During the next 48 hours her condition was not quite so favourable. She complained considerably of flatulence, and vomited on several occasions, bringing up a turbid bilious looking fluid, though at no time was the vomiting either very violent or excessive. There was, at the same time, a slight elevation of temperature, and the pulse rose to about 126 to 130. The tongue was rather dry, and somewhat caked with encrustation. She was ordered half-dram doses of a mixture containing equal parts of spir. chloroformi and sal volatile, to be given frequently in water, and subsequently a mixture containing bismuth and magnesia, the morphia injections being still continued. On the 8th the wound was again dressed under ether and spray, in the same manner as before, a very slight fœtor was perceptible, and on tightening the clamp pus welled up around the pedicle, this was carefully syringed away as far as could be, and a drainage tube inserted, iodoform was dusted on to and around the stump, and the adjacent parts of the skin painted with salicylic paste. There was considerable distension of the abdomen, but the greater part of the wound appeared firmly united. As everything taken by the mouth was speedily rejected, all nourishment was now given in the form of strong beef tea and brandy enemata which were well retained. By the 11th August the vomiting had entirely ceased, and to a less extent so had the flatulence, and she was able again to take her food by the mouth. Beef tea, broth, and brandy having become repugnant to her, she was ordered bread and milk, and champagne, which she appeared to enjoy.

The wound was dressed again on the 9th, and subsequently once on each day, much after the previous plan; especial precautions being taken by syringing with weak warm carbolic lotion to remove all discharges, and by drainage tubes inserted alongside the stump to prevent its accumulation. After the 11th we considered we could dispense with the ether and the spray. On this last named date, owing to the distension of the abdomen and the shrinking of the pedicle, there seemed to be some danger of its getting drawn back into the cavity of the belly through the wound, and in fear lest this calamity should occur, the stump was transfixed by a pair of Kœberle's transfixion needles, which effectually disposed of that risk. On this day also we removed the stitches from the upper part of the wound and applied strips of adhesive plaister almost completely round the belly to prevent any separation of the edges. With the tightening of

the clamp, to which a twist or two was given every day, the pedicle continued to shrivel and to become looser till, on the 14th August, ten days after the operation, it being no longer possible to tighten the wire, the clamp was removed. Preparation was made to replace it with a fresh one, but this was not necessary, as the shrivelled pedicle hung only by a very slender attachment. About one-third of the dead tissue forming this was gently cut away with scissors, and nearly all the remainder on the following day, on which also all the upper sutures were removed. The complete removal of the clamp and pedicle left a large open cavity from $2\frac{1}{2}$ to 3 inches deep, capable of holding about an ounce of fluid, the sides being covered with remarkably healthy looking granulations. This cavity, after gently syringing it out with weak warm carbolic lotion, was dressed by lining the sides with narrow strips of dry boracic lint, a plentiful supply of salicylic wool and carbolic gauze being placed over all to absorb the discharge which was at this time and henceforward entirely purulent and without the slightest fœtor. The patient expressed herself greatly relieved by the removal of the clamp and needles, of which she had frequently complained as pressing unpleasantly upon her.

From this period details of the case are scarcely necessary, as there was no interruption in the progress towards recovery. She returned to the Dorcas Ward on the 23rd much improved in general health. The cavity left by the removal of the pedicle very rapidly filled up, and now, on the 24th September, may be said to be entirely healed.

It is worthy of note that on the 28th August a thick silk ligature was found amongst the discharge, and on the 15th September two more. I recognised these, from the knots, as the ligatures placed on the broad ligaments, and I have not seen recorded any note of a similar occurrence. The material of the ligature appeared quite unaltered.

Two other facts not yet mentioned may also here be stated. The use of the catheter was abandoned on the 12th, eight days after the operation, and the bowels were moved for the first time on the 14th, ten days after the operation, after an enema. They acted subsequently with great regularity and usually without any aperient.

The patient's health has continued to improve to the present date, and after being fitted with an abdominal belt, she was allowed to sit up a little on the 7th September, and to attempt to walk on the 14th. I hope to send her very shortly to the Convalescent Home.

REMARKS.—Though it is manifestly unsafe to generalise from a very limited experience of this operation, yet the gratifying success, and the almost complete absence of bad symptoms which has attended it in this instance, confirm in a striking manner the dictum of Mr. Thornton with which I commenced this report. The case shows, also, as a remarkable physiological fact with what little disturbance of the system such important organs as the whole female reproductive system may be removed, even in spite of the increased functional activity conferred upon it by the presence of a large tumour. In the above case, after failure of medical treatment, there were only three means whereby the woman could be relieved of her troubles, assuming, as seemed abundantly clear, that the relations of the tumour were such as to prevent its being removed alone, viz.:—

1. Determination of the menopause by removal of the ovaries and appendages.
2. Removal of the uterus with the tumour by the intra-peritoneal or by the
3. Extra peritoneal method.

Though the operation was commenced with the intention, in some degree, of adopting the first-mentioned and least dangerous course, yet the almost entire absence of all adhesions, and the ease with which the whole tumour could be turned out of the abdomen, together with the less certain results that attend the simple removal of the uterine appendages, induced my colleagues and myself to adopt one of the latter alternatives. The gratifying success of the extra-peritoneal treatment in the hands of Péan and others has made me at least so strongly inclined to that method that I did not hesitate to adopt it. Though it is a tempting subject for discussion, it is not my intention, with a very limited experience of the operation in any form, to enter upon the relative merits of the two methods, but I will confine myself rather to pointing out some of the lessons I have learned from the operation as it was actually carried out. What must be strikingly apparent to all who have the slightest experience of the instrument is, the admirable facility with which a thick flesh pedicle can be controlled, and all hæmorrhage restrained, by a comparatively moderate pressure of the wire of Kœberle's *serre-nœud*. The chief difficulty seems to be to obtain a wire of sufficient malleability to be manageable, and at the same time to be strong enough to withstand a considerable strain. I used good stout copper wire, silvered, but, as has been stated, the first wire broke under what seemed to be a very moderate force applied to the screw. If I were to perform the operation again I should try platinum.

But, admirable as is the *serre-nœud*, I do not think it can be trusted alone to prevent the retraction which must take place if much distension of the abdominal walls takes place. For this purpose I can conceive nothing better than the transfixion pins devised by the same surgeon. These, when passed through the pedicle cross-wise, most effectually dispose of this danger. I was aware of their existence, and should have used them in the first place, if I had fortunately had them, but it was not until a few days afterwards that Dr. Gardner was good enough to lend me a pair. These I applied with much success, as related above. If I were to operate again, I should look upon them as a *sine qua non*. Without doubt the great difficulty of the after treatment in the extra-peritoneal method is the satisfactory management of the thick fleshy pedicle, which must necrose and be a perpetual source of danger from suppuration and putrefaction till it separates. In the preceding case, though there was perceived on one or two occasions some slight fœtor, putrefaction never appeared to be a real source of danger, but I was not happy until the slough had come away. I attribute the rapid shrivelling of the pedicle, in a great measure, to the application of the chloride of zinc (100 per cent. solution); but here also I learned a lesson, for I did not realise how very caustic is a solution of such a strength. In my zeal to apply it effectively I was not careful enough not only to confine it solely to the stump, but to take great precautions that it did not touch any of the surrounding parts. The want of sufficient care in this respect caused the adjacent healthy parts to slough, and thereby caused the cavity that was left after separation of the pedicle to be larger than it need have been. Any slight fœtor that was at first apparent seemed kept in check by the application of iodoform, which was not only sprinkled over the stump, but a small muslin bag filled with that substance was laid upon it. The salicylic paste seemed to me to prevent any excoriation by the discharges to the surrounding skin, and nothing could have suited the extensive granulating surface of the cavity than the dry boracic lint which was applied without intermission until the hole closed up. Careful examination of the parts, after removal, showed the tumour to be an ordinary fibro-myoma, and essentially interstitial in its relations.

In conclusion, I wish to state that I consider a very large share of the success of this operation is due to the efficient assistance I received at the operation from my surgical colleagues, Drs. Gardner, Ellison, and Gosse, to the careful attention of the house-surgeon, Dr. Poulton, and to the careful nursing she received.

SOME POINTS IN CONNECTION WITH THE SMALL-POX CASES LATELY LOCATED AT THE QUARANTINE STATION, PORT JACKSON.

READ BEFORE THE N.S.W. BRANCH B.M.A.

BY PHILIP MUSKETT, L.R.C.P. ET R.C.S.,
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THE subject of the short paper brought under your notice this evening is entitled, "Some points in connection with the small-pox cases lately located at the Quarantine Station," and through the courtesy of Dr. Mackellar, the Medical Adviser to the Government, I have been enabled to make use of the data collected during my stay at North Head. Following out the idea suggested by the Collective Investigation Records, which have been already issued by the British Medical Association, I thought it would be advisable to adopt the same principle in reference to the stage of invasion in variola.

It is deplorable to think of the disastrous effects which may accrue from variola obtaining a firm grip on this colony, unprotected as it is by lack of compulsory vaccination, and therefore the necessity for a positive diagnosis becomes the more imperative, yet it must be a matter for congratulation that the Health Department is so efficiently organised. Curschmann, in the monograph on small-pox in Ziemssen, says: "*In the initial stage, moreover at a time when as yet no trace of small-pox eruption exists, infection may take place, and infection is also possible during the period of incubation, which is generally free from every symptom of the disease.*"

In our standard text books it seems to me that enough prominence is not given to the absolute necessity of being on the alert when suspicious symptoms develop themselves, and thus be ready to anticipate the course of the disease; and I have endeavoured to show in the present analysis (though fortunately the cases are few) that the early history in all is fairly consistent as a whole.

Now with regard to the thirteen cases under care at the Quarantine Station, I formulated a set of queries in every instance, and endeavoured to obtain a full record with regard to the following points, viz.:—

The advent of the disease; the presence or absence of rigor or rigors; the temperature; the state of the tongue; Epigastric pain or tenderness; vomiting; the state of the bowels; headache; sleep—delirium; pain—its locality; paralysis of limb or limbs; state of the bladder; convulsions in children; with regard to roseola variolosa; with regard to deglutition; state of the skin; date of appearance of the eruption.

Name.	Advent of Invasion.	Rigor.	Py- rexia.	State of Tongue.	Epigastric Pain or Tenderness.	Vomit- ing.	State of Bowels.	Head- ache.	Sleep.	Pain Locality.	Para- lysis.	Bladder.	Roseola Variolosa.	State of Deglutition.	Skin.
1 G. W. M. (35)....	Premontory Catarrh. Can Identify attack	None	Yes	Coated	Unrestless	Yes	Constipation	Yes	Restless	Lumbar	None	Normal	....	Slight soreness	Moist
2 I. Ma. (3)	Identify attack	Age precedes. No convulsion.	Yes	?	Yes, Seemed as if in pain	No	Constipation	?	Restless	Piercing of legs on abdomen	None	Normal	....	....	?
3 W. A. Mc. (4)....	Suddenly	No convulsion.	Yes	?	Refused breast	No	Normal	?	Restless	Cross and fretful	None	Normal	....	....	?
4 E. S. (30)	Suddenly	Rigor	Yes	Coated	Pain	Yes	Somewhat relaxed	Yes	Restless	Lumbar	None	Normal	....	....	Moist
5 J. K. (19)	Suddenly	Rigor	Yes	Coated	Pain	Yes	Constipation	Yes	Restless	Lumbar	None	Normal	....	....	Moist
6 H. Q. (37)	Suddenly	Rigor	Yes	Coated	Pain	Yes	Constipation	Yes	Delirious	Lumbar	None	Normal	....	....	Moist
7 W. Mc. (37)	Premontory	Rigor	Yes	Coated	Unrestless	Yes	Somewhat relaxed	Yes	Restless	Lumbar	None	Normal	....	....	Moist
8 W. H. (41)	Identify attack	Rigor	Yes	Coated	Pain	No	Constipation	Yes	Restless	Lumbar	None	Normal	....	....	Moist
9 W. K. (35)	Suddenly	None	Yes	Coated	None	No	Normal	Yes	Restless	Lumbar	None	Normal	....	....	Dry
10 P. J. (24)	Premontory	None	Yes	Clean	None	No	Constipation	Yes	Restless	None	None	Normal	....	....	Dry
11 G. H. (33)	Identify attack	Rigor	Yes	Coated	Pain	No	Constipation	Yes	Restless	Lumbar	None	Normal	....	Pain in deglu- tition	Dry
12 J. O. (30)	Premontory	Rigor	Yes	Coated	Unrestless	Yes	Constipation	Yes	Restless	Lumbar	None	Normal	....	....	Moist
13 H. H. S. (34)....	Identify attack	Rigor	Yes	Coated	None	No	Somewhat relaxed	Yes	Delirious	Cervical Lumbar	None	Normal	Well marked roseola	Slight pain in deglutition	Moist

The facts deduced from these points seem to be more apparent when placed in this way :—

1. *Advent*.—In eight of the cases it began suddenly, without warning as it were—the remaining five cases are recorded as having had symptoms of pre-existing catarrh, though even in this latter case the patients were able to recognise the actual attack.
2. *Rigor*.—For seven of the cases rigor is given as severe; in four cases it is wanting, and in the infant and child it is precluded by their ages.
3. *Pyrexia*.—In all the cases there is a history of a rise of temp.
4. *State of tongue*.—In ten cases there was a foul or coated tongue; in one case it is recorded as clean; in the children's case the mother is unable to state.
5. *Epigastric tenderness or pain*.—In five there was severe pain; in four a sense of uneasiness is given; in three epigastric symptoms were wanting; and in the case of the infant the mother states that there was loss of appetite, and that the child refused the breast.
6. *Vomiting*.—In seven the vomiting was a prominent symptom; in the remaining six it was absent.
7. *Headache*.—Present in eleven of the cases; query in children.
8. *State of the bowels*.—In eight there was constipation; three were somewhat relaxed; and in two there was normal action.
9. *Sleep or delirium*.—In nine cases there was a condition of restlessness; in three delirium; and one is recorded as having slept well.
10. *Pain—its locality*.—In nine there was well-marked lumbar pain; one had pain in the cervical region in addition to lumbar pain; one was entirely exempt from pain; the infant was cross and fretful; and in the child there was flexing of legs on abdomen.
11. *Paralysis*.—With regard to paralysis, none.
12. *Bladder*.—In all the condition of the bladder was normal. No retention in any case.
13. *Convulsions*.—There were no convulsions in W. A. M., aged 6 months, or I. M., aged 2 years.
14. *Roseola variolosa*.—With regard to this point, in one of the cases I had a well-marked example, and in two others the patients speak of a rash over the abdomen and legs.
15. *Deglutition*.—Some pain noticed in three cases.
16. *Skin*.—In eight cases the skin was known to be moist; in two it is given as dry; of the rest no record.

The following is a typical case, in which careful

notes were taken all through the stage of invasion, and which may be found interesting.

H. C., æt. 37, surveyor's assistant, has been staying in a house for some time where four of the inmates have been affected with one of the exanthemata. First seen by me in the above on August 25th, 1884, 2.30 p.m. At the time it was noticed that he did not look well. He stated that he had been taken ill in the night. It came on suddenly as a shivering fit. Before he went to bed he felt quite well.

After the shivering fit he felt very hot, and perspired a good deal. He passed a very restless night, vomiting two or three times, with a persistent feeling of nausea.

T. 103, P. 108. The skin was moist, tongue coated, bowels confined. He complained of pain in the back, like lumbago. He had lost no power over his limbs, and passed his water freely. There was no erythematous blush over the abdomen or thighs. His soft palate, fauces, uvula, and back of pharynx were clear. He attributed it to a bilious attack, saying that he had suffered from it before, but that he felt worse this time.

Some of the other inmates of the hotel, with this case, accompanied me down to the quarantine station. He was kept away from the others, and on arrival at North Head was isolated.

August 25, 7 p.m.—T. 103, P. 104. Not much change. Has been vomiting slightly since admission. Complaining of thirst.

August 26, 9 a.m.—T. 101.8. P. 92. Does not look at all well this morning. Both conjunctivæ slightly tinged with jaundice. On tightening the skin at the back of the wrist the yellow tinge is plainly visible. Symptoms of epigastric disturbance. Has taken his food better this morning. Not so thirsty. Tongue still furred. Bowels confined. Says he feels better in himself. No headache. No dorsal pain. He vomited again during the night, and brought up a good deal of bile. Nothing to be elicited from the soft palate; but on the anterior pillars of the fauces and on the uvula are some whitish spots. Over the anterior aspect of the abdomen and thighs the condition is normal. There is no indication of an eruption on any part of the body externally.

2 p.m.—T. 102, P. 104. Does not feel quite so well. Has vomited his dinner, but retained the soda-water sent this morning.

7 p.m.—T. 104, P. 108. Has been vomiting a good deal during the afternoon. He cannot keep anything on his stomach, and threw up all his medicine. Looks very ill to-night. Feels very weak and unable to sit up. Skin feels moist. Breathing tranquil. No cough. Tongue

furred and flabby, indented by teeth at sides. Bowels confined to-day, but has eaten nothing to speak of. Passed his water all right. Complaining of severe headache.

August 27, 9 a.m.—T. 101, P. 96. This is the third day since he was taken ill. The rash came out this morning. The temp. has fallen from 104 last night. The rash is more abundant over the face and forehead than on other parts of the body. On the forehead it is particularly abundant and profuse. It is also apparent over both arms, and a few are observable on different parts of the trunk, especially on the dorsal surface. It is more profuse on the legs than on the arms.

In character it consists of a papular eruption, the papules being of small size, pale colour, and presenting a hard, limited, as it were, feeling to the touch.

Each individual papule can be distinctly felt. It is a hard, shotty feeling. On the soft palate three round opaque spots have appeared. On the soft palate, anterior pillars of the fauces, uvula, and back of the pharynx the eruption presenting the same appearance is observed. Skin moist. Breathing tranquil and normal. No cough or tightness of the chest. Appetite improved this morning. Not so thirsty. Tongue flabby, thickly furred. Bowels still confined. Has passed his water. No pain. Complaints of feeling weak. Passed a restless night.

The last case which I wish to bring under your notice is peculiarly interesting, as I think it prominently upholds the advantages derived from vaccination. The patient, H. H. S., was admitted to the quarantine station on September 12th in the evening, and vaccinated the next morning. Vaccination ran its due course; but on Sept. 25th, thirteen days after possible infection, symptoms of varioloid were manifest. The case is interesting, firstly from the fact that the disease was singularly modified by vaccination, and secondly because it presented an example of well-defined roseola variolosa.

On the subject of varioloid and roseola variolosa I have thought it advisable to quote a few remarks as bearing particularly on this case.

The following is from Austin Flint. He says :—

During an epidemic of small-pox, cases are sometimes observed in which all the symptoms of the stage of invasion occur without being followed by an eruption. The disease appears to abort spontaneously at the end of the stage of invasion. These attacks resemble febricula, but it has been observed that persons who have had these attacks during the prevalence of small-pox are thereafter insusceptible to the disease,

although not protected by vaccination. Hence it has been considered that the disease sometimes occurs without an eruption.

Again, further on, he observes : In varioloid the primary or eruptive fever, in the stage of invasion, is often as marked as in cases of natural small-pox. The duration of this stage may be longer than the average duration in ordinary variola. Frequently the eruption aborts to a greater or less extent. It may stop at the vesicular or even at the papular period.

In cases of varioloid, *oftener than in* ordinary variola, the eruption is liable to be preceded and accompanied by an efflorescence bearing considerable resemblance to scarlet fever.

Curschmann, in the monograph on small-pox, in Ziemssen, speaking of varioloid, says :—

We find, accordingly, frequent mention made of cases in which the disease runs an extremely mild course. A prominent characteristic of varioloid is that it exhibits far greater variations and irregularities than variola vera, in respect to the duration and course of its stages and the character of its symptoms. This is manifest even in the initial stage. The widespread opinion that this is always milder than the initial stage of variola vera is decidedly incorrect. To be sure, in very many cases, it is mild, and at times almost devoid of symptoms; but on the other hand *the most violent initial symptoms*, with intense fever and marked disturbance of the general condition, are observed by no means infrequently in quite insignificant cases of varioloid.

The following remarks culled from Ziemssen, with reference to the initial eruptions, may possibly be interesting :—

From an anatomical standpoint the exanthems observed during the stage of invasion may be divided into two forms—Erythematous and Hæmorrhagic.

The former are either diffuse, and cover more or less extensive parts, rarely the whole body (scarlatiniform exanthem), or they are macular or “measly.”

The hæmorrhagic exanthems are composed of extremely small punctate, often pin-head sized, hæmorrhages in the epidermis, which are more or less dense and at times so crowded together that the impression of a diffuse redness is produced.

The erythematous eruptions of scarlatiniform and measly form do not show any marked preference for particular parts, but they sometimes spread over the greater part of the body. But as a favourite seat of the hæmorrhagic eruptions the lower abdominal region and inner surfaces of the thighs may be mentioned, when the patient lies with his legs in contact this hæmorrhagic

eruption presents the form of a triangle, the apex of which is towards the pubes while the base crosses the abdomen transversely near the umbilicus.

The time of the appearance of these interesting eruptions, which imprint something extremely characteristic upon the often indistinct form of the initial stage, is tolerably variable. In general, however, the *second* day may be designated as that upon which they most frequently appear.

The duration of the initial eruptions is also extremely variable. The erythematous do not last as long as the hæmorrhagic and usually remain for 12 or 24 hours.

As regards the erythematous, that is the non-hæmorrhagic initial eruptions, it may be stated that they precede varioloid almost exclusively.

I do not remember, says Curschmann, having observed, out of a large number of cases, a single one where severe variola vera developed after a well-marked simple or erythematous initial eruption.

Viewed in this light, the purely erythematous initial exanthemata prove to be of decided prognostic value.

When they are well marked we may predict that, with great probability, the form of the disease will be mild. While after a well-marked petechial exanthem, variola vera will nearly always ensue, and not infrequently the confluent variety.

The following history shows the progress of the case from day to day:—

H. H. S., æt. 24. Three good vaccinia cicatrices, left arm, childhood. Re-vaccinated Sept. 18th, 1884. One taken successfully. One of the inmates of a house where small-pox had developed itself. Arrived at quarantine station Sept. 12, 1884, at the same time as the patient, and located on the healthy ground.

Thursday, Sept. 25th, 9 a.m.—Last night, a little after twelve, he was seized with a slight shivering fit, and was very restless during the remainder of the night. T. 101°; P. 96. Complaining of headache this morning, with pain in the lumbar region. Skin moist. Tongue foul. No epigastric tenderness. Bowels confined. Complaining of stiffness in the cervical region. Does not look at all well this morning. Injection of both conjunctivæ. Passing his water without difficulty. Taking into consideration the fact that he had been exposed to contagion on September 12 inst., and from these symptoms it was considered advisable to have him isolated, and watch the progress of the case.

2 p.m.—T. 103°; P. 100.

7 p.m.—T. 103°; P. 100. Has been taking his food fairly well during the day.

Sept. 26, 9 a.m.—T. 102·4. P. 104. Pulse

compressible dicrotic. Skin moist. Had a restless night. Has taken his food this morning. Tongue furred. On the palate and fauces are some whitish spots. No papular eruption visible on skin. The trunk is covered with a roseolous blush. It is very vivid, and disappears under pressure of the finger, returning on its removal. Bowels open three times this morning.

2 p.m.—T. 104° P. 100. Does not look at all well. Face flushed, with congested conjunctivæ. Skin moist. The vesicular-like character of eruption on palate more marked. No cough. Erythematous blush on trunk still. Tongue coated. Has eaten a little dinner.

7 p.m.—T. 103·4. P. 100. Skin moist. On the tongue are three patches of denuded epithelium in the midst of the coating. Face flushed. No pain in stomach. Complaining of stiffness in the back of the neck. Has passed his water.

Sept. 27, 9 a.m.—Third day of illness. T. 102·6°. P. 100. Skin moist. Tongue furred, with three patches of denuded epithelium near the median line. Face still flushed. Has eaten his breakfast. No tendency to vomit. Complaining of pain in cervical region. Slightly delirious last night.

Sept. 27, 2 p.m.—T. 103·4. P. 104. Face somewhat flushed still. Congested conjunctivæ. Tongue furred. Complaining of throat feeling sore. Skin moist. Bowels open again this morning. Passing his water without difficulty. Pain in cervical region still.

7 p.m.—T. 104°. P. 104. Skin moist. Tongue coated. There is a papular-like rash over the body. Most marked on the trunk. Essentially it is small in size, pale in colour, and on the forehead especially feels hard, indurated to the touch.

Sept. 28, 9 a.m., second day of eruption.—T. 102. P. 110. On the forehead and face the eruption is very sparse. More marked on the trunk, especially the anterior surface. Only one or two spots on the arms. Skin moist. Tongue furred. Was slightly delirious last night, with vomiting towards the morning.

2 p.m.—T. 102·8. P. 96.

7 p.m.—103·8. P. 92. Doing fairly well. Appetite fair. Complains of thirst. Tongue furred. Slight headache. Swallowing without difficulty. Skin moist.

Monday, Sept. 29. Third day of eruption. T. 100·8. P. 98. Tongue coated this morning. Skin moist. Bowels confined on Saturday. Appetite fair.

Monday, Sept. 29 (continued).—9 a.m.—The rash seems to be aborting. It is fading on the forehead and fainter on the trunk.

2 p.m.—T. 100·8. P. 88.

7 p.m.—T. 100. P. 92. Bowels open today. Complaining of pain in the back of the neck.

Tuesday, September 30, 9 a.m.—Fourth day of eruption. T. 100. P. 74. Had a good night. Sleeping well. Rash much fainter all over body. Tongue coated still. Taking his food well.

2 p.m.—T. 100. P. 80.

7 p.m.—T. 100. P. 78. Progressing fairly well.

October 1.—Fifth day of eruption. T. 99. P. 72. Had a fair night. On the forehead this morning are some raised hyperæmic like patches. In shape they are oblong; the intervening skin normal. On the trunk also the rash is more apparent this morning. On the back, about region of scapulae, some of it is desiccating. Tongue furred. Appetite fair.

2 p.m.—T. 99. Pulse 72.

7 p.m.—T. 99·8. P. 76.

SMALL-POX AT BORDER TOWN, S.A. A CONTRIBUTION TO THE HISTORY OF THE EPIDEMIC OF SMALL-POX IN AUSTRALASIA, DURING 1884.

BY ALFRED AUSTIN LONDON, M.D. (LOND.),
NORTH ADELAIDE.

EARLY in April, 1884, the P. and O. R.M.S. "Rome" arrived at Melbourne with a female passenger convalescing from small-pox, who landed there and was detained in quarantine. Shortly afterwards some fresh cases occurred in that city, and subsequently in the adjacent colonies of South Australia and New South Wales; and one patient, I believe, developed small-pox whilst on the way to New Zealand, and died in that colony. No fresh cases have been reported during the last month, and it is to be hoped that the outbreak is now at an end.

Jesse Collins, æt 22, an epileptic, who had recently left Trarlgon, in Gippsland, stayed in Melbourne at an hotel facing Old Sandridge Wharf from June 30th to July 2nd, and then left by the S.S. "Claud Hamilton," arriving at Kingston in the South East on the 5th, where he spent one night. The next day he commenced a tramp of 150 miles along the railway-line, which he completed in a week. Then, on July 13th, he was taken ill, after an incubation period of from 11 to 13 days, and found wandering about in a state of delirium, near a railway camp, twelve miles distant from Border Town. That night he was maniacal and required to be held down; and on the next day (July 14th) he was arrested by the police as a

lunatic, and taken to the Border Town police-station. His early symptoms, besides the delirium, which was mild during the day time, but furious at night time, were a sensation of coldness and severe pains in the loins; but no rigors were noticed apparently, nor any vomiting. On the third day of his illness the rash appeared as papules on the wrists; on the fourth day the face was described as "swollen and shining like a bladder;" by the fifth day the rash was widely distributed over the whole body, and in some situations had coalesced, and huge blebs had commenced to form on the feet. On the sixth day the mucous membranes of the eyes, nose, and mouth were implicated and discharging profusely, and the odour from the patient was so offensive as to make one of his attendants vomit. The spots were now vesicles, with an inflamed areola. Subsequently they became umbilicated, and then pustular with dark central dots. On the eighth day the rash was at its height. Meanwhile the delirium and other symptoms had disappeared; soon scabs commenced to form and fall off in enormous quantities, leaving deep brown stains, in the centre of which scars and pits were soon apparent, and epistaxis was now of frequent occurrence. After the tenth day he began to improve rapidly, but the scabs had not all fallen off till the end of the fifth week, and then there still remained some desquamation on the feet. The confluent patches were composed of some hundreds of spots, but, where discrete, the pocks showed the typical arrangement in groups of threes and fives, and I estimated that he had about 3000 spots altogether, being literally covered from head to foot. At the end of the seventh week the pigmentation, which was a very remarkable feature of the case, had only slightly faded, but the scarring and pitting were still more evident on the mucous, as well as the cutaneous surfaces.

Mounted-constable Bruce, æt. 28, was taken ill on the fourteenth day from the date of his first coming into contact with Collins. His early symptoms were general malaise, with pains in the head, back, and side; a papular rash appeared on the fourth or fifth day, many of the spots aborted, but some matured, and have left in a few instances typical scars. His case was one of variola, modified by vaccination, the attack being slight, and convalescence rapid.

Mounted-constable Thornton, æt. 31, arrested Collins on July 14th, and was taken ill with shivers and other febrile symptoms a fortnight later. His rash was noticed first on the fifth day, and was then universally distributed over the whole body as red papules, which sub-

sequently became vesicular, umbilicated, pustular, and then either burst or formed scabs. After a fortnight he was convalescent, and at the end of a month most of the spots had disappeared, leaving pits in only a few cases. This was also a case of modified variola.

At first Dr. Penny attended the cases, but he did not arrive at any positive diagnosis. He isolated Collins, but the constables went about the town as usual; and when Bruce was taken ill he went to a boarding-house in the town, where they subsequently burnt the bed-clothes and took other precautions. On August 2nd Dr. Parker arrived and established quarantine, Bruce being ordered back from the town. Dr. Parker thought the cases to be "aggravated chicken-pox," but subsequently came to the conclusion that they were instances of what is known as "native-pox." On August 8th I relieved Dr. Parker. Quarantine was kept up till August 30th, but Collins remained in custody till September 16th, as he had not completed his desquamation. It is interesting to note that none of the navvies at the railway-camp contracted the disease, which is said to be infectious before the appearance of the rash; but that on the twelfth day after its appearance one constable was taken ill, and on the thirteenth day, the second constable. The usual precautions were taken to prevent the spread of the disease and to disinfect the premises, and none of the other inmates, who at one time numbered fifteen altogether, took the disease.

REMARKS.—It seems somewhat humiliating that in all three colonies the same mistake should have been committed of not recognising a case of small-pox until the infection had been allowed to spread; and it is the more unfortunate since the results in some instances have been fatal. I think you will all agree with me that a well marked case of confluent small-pox, such as that which I have narrated, ought never to have given rise to any doubt. I could not at first understand how chicken-pox (a disease of childhood and most rare in adults) could have been diagnosed; but the President of the Central Board of Health (Dr. Whittell) has thrown some light upon this point. He informs me that in these colonies the laity and many of the profession use the term "chicken-pox" to denote vaguely any form of pustular eruption which is not small-pox, and that when they designate a disease chicken-pox, they do not necessarily mean true varicella, and moreover that they often use the term "native-pox" in precisely the same sense. The cases of so-called "native-pox" which Dr. Whittell has seen, and which were not chicken-pox, appear to him to closely re-

semble the disease first described by the late Dr. Tilbury Fox as *Impetigo Contagiosa* (the *Porrigio* of other writers), the course of the disease being generally chronic, the spots coming out in crops and being contagious. Occasionally he has seen the disease run a sub-acute course, and in one instance it was followed by albuminuria; but he has never seen it behave after the manner of acute infectious diseases.

THE PRESENT OUTBREAK OF SMALL-POX IN NEW SOUTH WALES (ILLUSTRATED).

THE first cases which appeared were those at the Orient Hotel, Lower George Street, Sydney, of whom there were five when first recognised as suffering from variola by Dr. J. Ashburton Thompson, the inspector under the Board of Health, on his first visit on Aug. 23rd. These were immediately removed to the hospital at the Quarantine Station, North Head, and all persons who had been exposed to the contagion were taken to the healthy portion of the same place and kept under observation. It was for his omission to report these cases that Dr. Eichler, the medical practitioner who had been attending them was prosecuted, and on his pleading guilty to the charge was fined £10, the lowest penalty, with costs. The names of these first patients were—Ida McCombie, aged 2 years; George Walter Mantell, 38; Walter Albert McCombie, 5 months; Eliza Smith, 35; and Johanna Kenny, 20. The following is the portion of Dr. Ashburton Thompson's report which gives the reasons of his diagnosing these cases as variola:—

"I consider that all of these persons are suffering from small-pox, and I base my diagnosis upon the following facts, collected from the whole group:—The *prodromal* stage lasted forty-eight hours (case E). The rash appeared first upon the face (A, B, C, D, E). At the time that the face and forearms were covered with a confluent roseola and copious rash the body showed but a very sparse rash (E). There was a distinct *eruptive stage*, which lasted about forty-eight hours (D and E). The *stadium floritionis* was ushered in by a marked fall of temperature (E, from 104.4° to 101.1°). There was sleeplessness (E). The *stadium floritionis* endured until the eighth day of illness, when it began to give place to the *stadium esciocationis* (C). On the sixteenth and seventeenth days respectively cases B and A showed the usual signs of this stage at that

1.



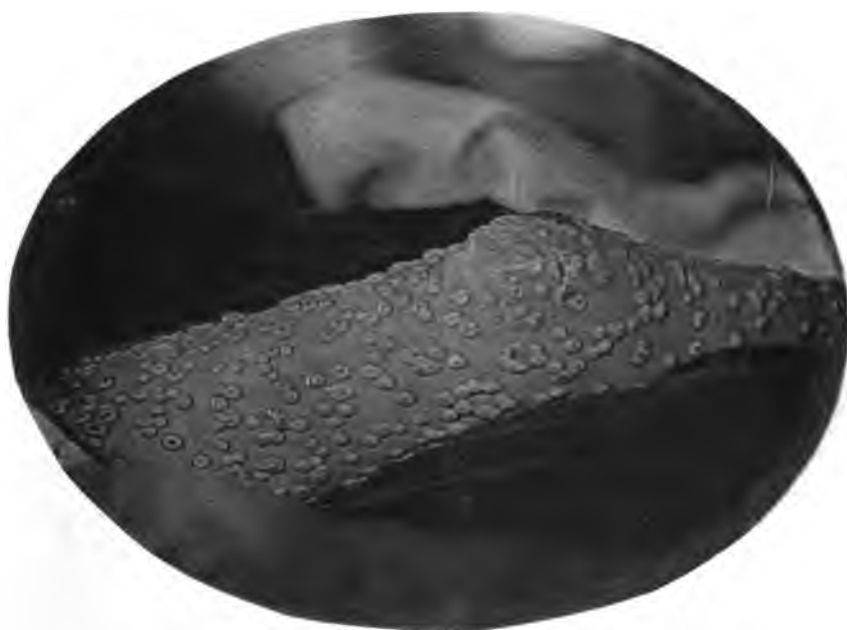
2.



3.



4.



period of disease. The site of some vesicles from which the scabs had already fallen was marked by a smooth deep brown stain; that of others, by still adhering crusts; on the palms of the hands the brown pigmented matter had the appearance of being encysted (A and B). During the *stadium floritionis* the rash consisted of circular flattened or umbilicated vesicles, of a dead whitish-yellow colour, which did not collapse upon being pricked (C). No known disease answers to this description except small-pox.

It is not likely that exception will be taken to this method of diagnosing the disease from the symptoms presented by the whole group of cases, because that kind of criticism would be unphilosophical; nevertheless, I may point out that the diagnosis can be equally well based upon the facts of case E alone. No known disease corresponds with those facts except small-pox.

In conclusion, it may be useful to give the reasons which exclude chicken-pox from consideration specifically:—

1. Chicken-pox is a disease of childhood, which only attacks adults rarely. This disease has seized three adults; and only two children out of four exposed to contagion.
2. Chicken-pox is never a serious illness. The lives of three of these persons are endangered.
3. Chicken-pox appears first upon any part of the body indifferently. In all of these cases the rash appeared first upon the face.
4. The stadium prodromorum of chicken-pox seldom exceeds a few hours. In two of these cases it is seen to have lasted forty-eight hours.
5. The rash of chicken-pox becomes vesicular within a few hours—never more than twelve; in these cases the papules only become vesicular on the third day.
6. The vesicles of chicken-pox become rapidly large; they are irregular in shape, and full of transparent fluid; they collapse on being pricked; they are surrounded by a very faint areola; they form crusts within a week, which soon fall, and nothing is left but a faint redness. In these cases the vesicles took eight days to reach their full development; they were then circular, flattened, or umbilicated, opaque, and whitish-yellow in colour; they did not collapse on being pricked; they were surrounded with a bright red areola; even on the eighth day no crusts had formed, and so late as the seventeenth day some crusts were still adherent; the former site of crusts is marked by a deep brown stain.

In fact, between small-pox and chicken-pox there is no resemblance whatever. Some difficulty may be felt in discriminating between small-pox, modified by previous vaccination, and chicken-pox, during the earliest days of illness; but the lapse of a short time suffices to make the diagnosis both easy and certain. It is only when a case is seen for the first time after the crusts have formed that it is sometimes impossible to decide between post-vaccinal (or modified) small-pox and chicken-pox, with absolute certainty."

These five cases were followed by nine others at intervals up to Sept. 25, making, during this first portion of the outbreak, fourteen in all. Dr. Thompson says:—

"Of these fourteen cases seven came from the Orient Hotel. Of the other seven, one (Hughes) was certainly infected by visiting that house, another (Jonsen) very probably, and a third (Hillis) perhaps so. Of the remaining four, Saunders was most likely infected by

Hammond, judging from the dates at which they respectively sickened. Three cases remain, viz., Kingston, Hammond, and Olsen, in which the source of infection cannot be named. Kingston received his infection before the Orient Hotel was quarantined, and while it was infected, and he may have visited it or have come into contact with one of the inhabitants. Hammond also may have been infected there, but in that case the incubation period must have lasted seventeen days. This is possible, but not most likely. In the case of Olsen, if it be granted that the incubation in his case lasted eighteen days, the same explanation may be suggested. At all events this group of cases affords no ground for apprehending an epidemic of small-pox, but every ground for assigning such small spread of the disease as has occurred to contagion, not always traced but traceable, although the manner in which the latter was carried cannot be ascertained in the three cases named."

After this date no case was observed outside the quarantine ground for a period of thirty-nine days, when, on Oct. 25, a woman named Olive Byrnes sickened. She was first seen by a doctor on Nov. 1, who reported the case to the Health Department as one of small-pox, and she was removed to the quarantine hospital. She was visited by Mr. William Baird, junr., on Oct. 31 (the day before a doctor was called in), and he developed small-pox on Nov. 13, being quarantined on Nov. 16. Other cases were reported as follows:—On Nov. 14, Mrs. Stratton; on Nov. 25, C. A. Israel; on Nov. 28, Nellie Edwards, James Brady, Sophia Barry, Charles Tyler; Nov. 30, Hermann Dechow.

Dr. Thompson, in his report to Dr. Mackellar, says:—

"On this date the case of Hannah Christianssen, æt. 33, 292, Elizabeth-street, was reported as being small-pox by the doctor (E) in attendance. She found herself not well enough to rise on Nov. 25; some spots appeared on her face towards evening on Nov. 28; on Nov. 29 a rash was visible over the whole body. Nov. 30 she was covered with a discrete eruption, which was thickest on the face, and which was the eruption of small-pox at the third day. On inquiry her husband told me that he did not know where she caught her illness, but that if the eruption he saw on her were small-pox, then the baby living next door, who had for some time been attended by Dr. Donovan, had had small-pox too. Now next door lived Mrs. Cohen, in whose service was Olive Byrnes up to Oct. 16.

On receiving this information, I at once called upon Dr. Donovan, but he was not at home. I then reported to you, and I learned that you had already been informed that Charles Tyler had done some work in Cohen's house on Nov. 10. Together we visited Mr. Cohen, and we examined the family; we found that Joseph Cohen, æt. ten months, unvaccinated, had recently suffered from small-pox. We were told that his illness began on Nov. 8 (my former visit was paid Nov. 1), that Dr. Donovan visited the child on the 4th; and that when he called on the 7th, a neighbour was present who asked him if he were sure that the disease was not small-pox; we found the child's face much pitted, but the skin had in other respects nearly recovered its normal appearance; the body was covered with discrete blotches not yet showing pits, which were purplish on the legs, reddish brown or brown upon the

trunk. You left me with the intention of calling upon Dr. Donovan; and later in the evening, at your request, I visited the three following cases.

"Harry Kingsbury, 11, Chapel-lane, set. 8, unvaccinated, scholar, Crown-street School; class 5th, infants; last there Nov. 21; he fell sick Nov. 23; Dr. Donovan first saw him Nov. 25; a rash first appeared in the early morning of Nov. 26; I found this child covered with the rash of small-pox at about the fifth day of eruption; it was very thick set everywhere, and on the face, and on every other part of the body was confluent; the vesicles were circular, flattened, umbilicated, and surrounded with a bright areola; they were set upon an indurated base; he was very seriously ill, and is not yet out of danger.

"Rachael Marks, 137, Campbell-street, set. 7, unvaccinated, scholar, Crown-street School; class 5th, infants, last there Nov. 21. I was told that she fell sick at 4.30 a.m. on Nov. 24; on Nov. 25 Dr. Donovan visited her; Nov. 26 a rash was visible, which was supposed to be scarlet fever or measles, and Dr. Donovan called again; Nov. 27 the rash now took the form of distinct spots; Dr. Donovan called again. Nov. 28 the spots had increased in size; Dr. Donovan called. Nov. 29 Mrs. Marks told me that she had seen small-pox, and suspected the true nature of the child's illness; and on this date she called upon Dr. Donovan and, in order that the doubt which existed in her mind, notwithstanding Dr. Donovan's assurance that the illness was not small-pox, might be allayed, she insisted upon a consultation being held. This was done on November 30, and Dr. Donovan then confirmed his opinion already expressed. On the evening of this day, I found the patient covered with a confluent vesicular rash, the face swelled, and the features obscured. Where the vesicles were isolated they were circular, flattened, umbilicated, milky white, surrounded by an areola. This, too, was the rash of variola at the 4th-5th day. This child was for some time in jeopardy, but now seems to be likely to escape with her life.

"Emma Low, 196, Oxford-street, set. 12 years, unvaccinated, scholar, Crown-street School; class, lower 3rd, girls; last there, 28th, in the morning. She fell sick Nov. 23, and the rash first appeared, and on the forehead and chest, on the morning of the 20th. Dr. Donovan visited her on this day. I found the child covered with a confluent rash of variola at the 4th-5th day, of which the description would be that just given in the cases of Kingsbury and Marks. This child is still in danger.

"The origin and spread of the contagion which affected this group of cases is an exceedingly interesting and instructive subject. I premise an account of it with this statement, that although the incubation period of small-pox is less than fourteen days rather often, it is very seldom longer; and that in the vast majority of cases it is exactly fourteen days or, precisely, thirteen times twenty-four hours. Now, Olive Byrnes having sickened October 25, she received the infection not earlier than October 12, or four days before she left Mrs. Cohen's. Did she catch her illness outside the house, and bringing it in (as a mere mechanical carrier) and infect Joseph Cohen? Joseph Cohen fell sick Nov. 3. He was probably infected therefore not earlier than Oct. 21, or five days after Byrnes had left the house. She left no things behind her when she went; she did not return there. That she should have brought a scab or contagion in a solid form into the house on Oct. 12, and have left it where the baby could come into contact with it nine days later, although possible, seems to me to be improbable in the highest degree. Did she infect the baby herself, physiologically? I am not aware of any evidence showing that persons communicate small-

pox during the period of incubation, except Ourschmann's case, in which a piece of skin taken from a person who was incubating small-pox did give that disease to the person upon whom it was engrafted; but that which is possible under such exceptional conditions is in all probability impossible under ordinary conditions; nor is it known to occur. The facts of these two cases appear to me to warrant one conclusion only; that Byrnes and Joseph Cohen were infected from a common source, with which the household was in communication. There seems no reason to suppose that this source existed in the house itself. Either an affected person visited Cohen's from time to time; or an infected person visited Cohen's from time to time. The latter may have lived in an infected house; or some member of the Cohen household may have entered an infected house on two—but probably on several occasions. In either case I conclude that there have been other concealed cases of small-pox than those which have just been discovered.

"But, accepting this house as the starting-point, the connection between it and all of the other twelve cases has been made out clearly enough. Baird and Stratton were infected by Byrnes, as has been already shown. Israel's case occurred next. He did not know Cohen, and had never been to the house, but his brother was a visitor there (he has fallen ill of small-pox at the quarantine of observation), and he was in his brother's society every day, and one of Cohen's family often visited the warehouse in which Israel was employed. Edwards was at Crown-street School, in the upper 3rd class, girls; Low was in the lower 3rd class, girls; and Leah Cohen was in this same class in the lower division, and continued to attend until Nov. 20. Marks and Kingsbury were in the 5th class, infants; Rose Cohen was in the same class and attended until Nov. 20. Dechow was in the lower 3rd, boys; Samuel Cohen was in this class, and attended until Nov. 20. Barry was in the lower 2nd class, girls; no connection between her and Leah or Rose Cohen can be shown, but I believe that all classes mix in the play-ground. Brady used frequently to meet Isaac Cohen. Tyler did a day's work in Cohen's house. Christiansen (two cases) lives next door to Cohen.

"Having shown that on this occasion also the spread of the disease has been by traceable contagion, which in all cases but one has been traced, and that there is, therefore, no reason at present to apprehend an epidemic."

Several of these cases being so typically variola, the idea struck Dr. Mackellar, the Principal Medical Officer, that it would be of great advantage and importance to have photographs of them. Accordingly, he personally proceeded to the quarantine ground, accompanied by Dr. Ashburton Thompson, who, to his other accomplishments, adds that of being a good amateur photographer, and, with all necessary precautions to avoid bringing away contagion, these gentlemen succeeded in taking numerous admirable negatives of the various cases. Heliotype prints from four of these, viz., the face and hand of Emma Low (Plate 1 and 2), and the face and leg of Harry Kingsbury (Plate 3 and 4), showing the state of the rash on the ninth day of the eruption, we are, by the courteous aid of the Honourable Geo. R. Dibbs, M.P., the Colonial Treasurer, and of Dr. Mackellar, able to issue, for the information of our readers, in this number of the *A. M. G.*

ASSOCIATION INTELLIGENCE.

SOUTH AUSTRALIAN BRANCH.

MONTHLY MEETING.

Held at the Adelaide Hospital, October 30th, 1884.

The President, Dr. C. Gosse, in the chair.

EXHIBITS.

Dr. Gardner exhibited a patient from whom he had removed the os calcis and astragalus, causing remarkably little deformity.

Dr. Lendon demonstrated the delicacy of the picric acid test for albumen on some urine, specific gravity 1011, from a case of granular contracted kidney, in which the cold nitric acid test had shown no re-action.

Also Dr. Oliver's test for albumen, consisting of potassio-mercuric-iodide with citric acid.

Dr. Thomas stated that the urine was procured from a gouty, elderly gentleman, who, a few weeks ago, showed unmistakable uræmic symptoms. These included an ill-defined attack of pyrexia, followed by vomiting, severe headache, and slight occasional wandering. The urine was very copious, of low specific gravity, and contained slight but unmistakable indications of albumen when tested by heat and nitric acid. At present heat yields no re-action, and at this moment nitric acid gives none. Picric acid and potassio-mercuric-iodide yield a decided but faint re-action.

Dr. Poulton exhibited a girl, aged nine years, suffering from cyanosis. The extremities and face presented a dull leaden hue; the respiration was rapid and painful on the least exertion; the fingers broad, cold, and spade-like at the extremities, and thickly studded with warts. The child was recovering from an attack of stomatitis, accompanied by hæmorrhage. There were loud, irregular, cardiac murmurs heard both at the aortic and mitral areas. The cyanosis was first noticed by the mother at about twelve months of age, and the girl was said to have improved in general health since her arrival in the colony four years ago.

Respecting the custody of the pathological specimens, the president informed the members that it had been agreed at a special council meeting to ask Dr. Poulton to take temporary charge of them, and preserve any additional ones that may be presented until other arrangements might be made, and further that the association incur no additional expense therewith in the meantime; and that Dr. Poulton had kindly consented to do this.

A. A. Lendon, M.D. (Lond.), then read a contribution to the history of the epidemic of small-pox in Australasia during 1884. (See page 61.)

Mr. HAYWARD considered that the so-called "native-pox" was simply impetigo contagiosa. He could, however, from personal experience, say that it was not always easy to distinguish chicken-pox from small-pox when occurring in children. In one case he remembered the fact of its being small-pox was only convincingly brought home to him, by his contracting that disease from the child. It was quite different, however, in the case of adults, and it seemed to him impossible that the two diseases could be confounded in such a case as that described by Dr. Lendon.

Dr. THOMAS could see no difference between "native-pox" and the various impetiginous diseases which occur in Great Britain, any more than he could detect anything specially characteristic in scabies as met with in the colony. His experience had only been amongst Europeans, so that he could not say that there might

not be some form of pustular disease peculiar to the natives.

Dr. PATERSON asked if the constables at Border Town had been vaccinated, and had well-marked vaccine scars. (Yes.) He agreed with the previous speakers that there was nothing specifically characteristic about the so called native-pox, and that it corresponded to the description of acne-pustulosa, or impetigo contagiosa. He had seen it in white children, but never in aboriginals. If the pustules alone were considered, there might be a difficulty at times in distinguishing between the eruption of native-pox and modified small-pox, but he thought a correct diagnosis could always be made by referring to the history of the case and the sequence of symptoms, small-pox being always an acute eruptive disorder, running a definite course, whereas native-pox was more chronic, there being successive crops of pustules during the progress of the disease. He had seen a pustular form of scabies occurring along with secondary syphilis, which was at first sight perplexing and gave rise to hesitation in forming a diagnosis, especially at a time when there were rumours of small-pox in the colony; but a careful examination of the eruption and observation of the symptoms with the history, easily set all doubt at rest; and the disease yielding to sulphur treatment more fully confirmed the correctness of the diagnosis of scabies.

Dr. MACINTOSH had never seen what is called "native-pox" amongst the natives. He said it was totally distinct from small-pox; it was more like impetigo. He did not believe in the modifying effect of the climate on small-pox. He had seen small-pox in the old country, in Edinburgh in 1872, and, also when it occurred in the ship "British Enterprise," at Port Adelaide in 1879, and in both cases the disease was identical in appearance and in the course it pursued. He could not understand how small-pox could be readily confounded with anything else, for if its stages were watched, it could easily be detected from its distinctive characteristics.

Dr. VERCO said he could not recognise native-pox as a distinct disease from impetigo or varicella. He was of the opinion that impetigo and chicken-pox were definite diseases, and separate ones. In children he thought that it was not always easy to distinguish chicken-pox from variola. He had seen a case of the former, where the constitutional symptoms were quite as severe, and the rash as abundant as in severe variola, each spot becoming petechial and leaving a definite pit, and yet there had been no history of any possible contagion with the variolous person; in fact, two other children had ordinary chicken-pox at the same time. Under such circumstances it would be impossible to call the case one of small-pox.

Dr. LENDON thought that a confluent case of small-pox should never be mistaken for anything else.

Dr. GOSSE could not agree with Dr. Paterson in what he had said respecting scabies. The ammonia-chloride treatment, recommended by Tilbury Fox, would be efficacious in either case, so that no distinction could be drawn unless the parasite were discovered. He also differed from Dr. Verco in thinking that patients had a difficulty in distinguishing between chicken-pox and native-pox; it was rather that they called nearly all scabby eruptions in children by the name native-pox. In his own mind, he had no difficulty in recognising the disease as impetigo contagiosa. He thought it would be a good thing, perhaps, if the profession took more pains to eradicate the name "native-pox."

CHARLES GOSSE, M.D., then read notes of a Case of Puleating Exophthalmos:—

A CASE OF PULSATING EXOPHTHALMOS.

By CHARLES GOSSE, M.D., OPHTHALMIC SURGEON,
ADELAIDE HOSPITAL.

ADA G—, *æt.* ten years, first consulted me on the 3rd April, 1882, for protrusion of her right eye. Seven months previously to my seeing her she had received a blow from the end of a parasol between the inner angle of the right lower eyelid and the skin of the nose. She suffered no pain or other inconvenience at the time of the accident, but three months afterwards double vision commenced, which has remained ever since.

The following was the condition upon examination:—Both eyes are much injected, and are naturally prominent. There is no pain in either, and the tension is normal. The right eye is certainly more prominent than the left, and it has a convergent squint of $1\frac{1}{4}$ " with homonymous diplopia; vision in the right eye gives $\frac{1}{8}$, and she reads No. 1 Snellen; whilst in the left she sees $\frac{1}{8}$, and reads No. 1 Snellen. With the ophthalmoscope, in the right there is a hypermetropic refraction, and the retinal veins are somewhat distended; the arteries and retina are otherwise normal. In the left eye the ophthalmoscopic appearances are natural. I saw her again on the 15th May, 1882, and the following are the notes which I have:—The right eye is more prominent, and the conjunctival veins are very much distended and congested. With the ophthalmoscope the retinal veins are very much enlarged, and pressure on the ball of the eye renders the veins quite empty. At this examination I noticed distinct venous pulsation in the retinal veins; in other respects the eye looks very much as it did on the first visit. The left eye has altered considerably, and is gradually assuming appearances similar to the right, the conjunctival veins being distended, and a general congested look about the whole eye; there is, however, no protrusion of the ball.

I did not see the patient again until the 12th of June, 1884, but I ascertained from her friends that during the interval the left eye had given her a good deal of trouble, and had become almost as prominent as the right, but had gradually receded. Upon examining her on the above date, I found the appearances, which the right eye and cheek presented, to be as follows:—The eyeball, which is very prominent, has a convergent strabismus of $1\frac{1}{4}$ ", and there is no movement outwards beyond the middle line. In the depression formed by the side of the nose and its junction with the inner angle of the eye there is a rounded swelling about half the size of a date stone. The whole of the

upper lid is distended with veins, and there are some in the lower lid also, giving the eye an cedematous look. In the substance of the cheek, which is thickened, there is a feeling as if a bundle of worms was being pressed between the fingers, and this extends down to the angle of the lower jaw. The swellings about the lids are soft and compressible, and a vascular thrill can be felt in the upper lid. On applying the stethoscope to the closed upper lid, a loud bruit can be heard, which is very much increased on placing the instrument on the right temple, the sound in this latter situation resembles the puffing of a steam engine. When the common carotid is compressed, the pulsation almost ceases. The vision in the right eye is worse than when last tested, as she can only see $\frac{1}{8}$, and reads No. 2 Snellen. With the ophthalmoscope venous pulsation is very marked, and the retinal veins still remain much distended and tortuous, the optic disc is slightly red, but otherwise normal. With regard to the left eye, it is not more prominent than at the first visit, and with the exception of some prominent veins on the conjunctiva, the eye looks natural, and the sight is good.

She was then admitted to the Adelaide Hospital, and after remaining for a few days under my care was transferred to Dr. Stirling. After consultation, it was decided to tie the common carotid artery on the right side. It was Dr. Stirling's intention to have added his notes to mine, but unfortunately his departure for England rendered this quite impossible, owing to the little time he had at his disposal. However, I must just give the leading points of the case whilst under his care taken from Dr. Poulton's notes.

Dr. Poulton says he was unable to feel the vascular thrill just prior to the operation, in other respects her condition was similar to my description. On the 28th June, Dr. Stirling tied the right common carotid with a kangaroo tendon, using antiseptic precautions, but no carbolic spray. The pulsation ceased immediately on the application of the ligature, and no sound could be heard with the stethoscope applied to the upper lid or temple. The wound healed by first intention, and there was no return of the pulsation. She was kept in the Hospital for some time after the wound had healed, for purposes of observation, as the eyeball did not appear to recede as we had anticipated. The last note, prior to her discharge on the 31st August, I find states that the eyeball still projects, but that the girl herself and her friends think that it is less prominent than before the operation. My own impression with regard to her condition is that the swellings around the eye in both lids are much

less prominent, but that the eye has not gone back into the socket very much. She expresses herself as feeling quite well.

On referring to the last number of the transactions of the Ophthalmological Society, I find a case very similar to the one I have just read, reported by Mr. Adams Frost, and as he goes into the probable pathology of these cases, I will, with your permission, trespass a little upon your valuable time.

Nearly all observers in recent years, are agreed that the cause of the symptoms in the majority of these cases is the existence of a communication between the internal carotid artery and the cavernous sinus, and consequent distension of the orbital veins which form the pulsating swelling in the orbit. In the case I have brought before you this evening, I do not think there is a doubt but that is the cause.

This view of the pathology of the affection is comparatively a recent one, and it is interesting to glance at the various stages by which it has been reached. Travers, in 1809, was the first to bring forward a case of Exophthalmos, and from that time up to 1859, no one who recorded cases of the kind, seems to have suspected that the symptoms might be due to any other cause than to an aneurismal affection within the orbit, although it was disputed whether this was a true aneurism, an aneurism by anastomosis, or an aneurismal dilatation of the ophthalmic artery in its whole course.

In 1859 a new light was thrown upon the pathology of this affection by the publication by Mr. Hulke of a case which had been under the treatment of Mr. Bowman. This case is well known, and here are the leading points. A woman, *æt.* 40, received a blow which fractured the lower margin of the orbit. Soon afterwards the characteristic symptoms of pulsating exophthalmos made their appearance. The common carotid was tied and the symptoms disappeared, but the patient died from the effects of secondary hæmorrhage on the 18th day. At the post-mortem no arterial lesion was found, but the orbital veins were dilated, and the cavernous sinus and its tributaries filled with puriform clot. It has been suggested that these changes were recent and consequent upon the operation, and that the original lesion was a small fissure in the artery which was overlooked, but the possibility of this being the case has been denied by Hulke, who is an exceptionally careful observer. Moreover, in a case recorded by Aubry, no such explanation seems admissible. The symptoms came on after an attack of enteric fever, and persisted until the patient's death, from an independent cause, four years later. The cavernous

sinus was found to end posteriorly in a *cul-de-sac* and no communication between it and the inferior petrosal sinus could be discovered. However, we may explain the pulsation in these two cases; there can be no doubt as to the effect the first has had in modifying the views of the pathology in this country.

In 1865 Mr. Nunneley read a paper in which the following occurs. In the great majority of cases of protrusion of the eyeball there is no disease whatever in the orbit, the seat of it is most commonly intra-cranial, the protrusion of the eyeball is passive, and the other symptoms are secondary and depend on obstruction of the return of blood through the ophthalmic vein. Here we have a distinct advance in the pathology, and the missing link was supplied by Deleus in 1870, who, in a monograph, shows that in addition to what may be termed the passive obstruction to the return of blood from the orbit through the veins, there is in most cases an arterial propulsion of blood *into* the veins, owing to the existence of a communication between the internal carotid artery and the cavernous sinus; a conclusion which has been amply confirmed since, by other observers.

In all cases, where post-mortem examinations have been performed, the orbital veins have been found dilated, and in these, where pulsation was present, the pulsating swelling was formed by the distended vein. Of course, we must except cases of orbital tumour.

In my own case, which resembles Mr. Bowman's very much (particularly in this respect, namely, that ligature of the common carotid artery, cured the symptoms in both cases), there is a distinct connection between the symptoms and the injury. I think that the injury sustained by the child caused fracture of the floor of the orbit, and so disturbed matters, that an arterio-venous communication was the result. This led to the varicose dilatation of the orbital veins, which extended to the other eye, by way of the transverse and circular sinuses. How to explain the cause of the left eye spontaneously recovering without any interference, I know not.

Injury, either in the form of fracture of the base of the skull, or by thrusting sharp bodies into the orbit, or by the entrance of shot, seems to have been a very frequent starting point of the symptoms of pulsating exophthalmos. Thus, of 110 cases reported, 65 were of traumatic origin.

With regard to treatment, there does not seem to be much scope for the ordinary palliative method, usually adopted in cases of aneurism. Digital compression is not well born as a rule in the region of the neck, and therefore, we have to look for other means to ensure a good result. In

ligature of the common carotid we have an operation which yields very satisfactory results, if reliance is to be placed upon the published records of cases. Out of 63 cases of ligature for the cure of this affection, 31 were cured at once, and as far as is known permanently, 8 were partially cured; in 13 there was a relapse, but a cure was subsequently effected by other means (in two by ligature of the other carotid). In one no effect was produced, and in one other, in which both orbits were affected, a relapse occurred in one. Fourteen cases were fatal, 7 from the effects of the operation, one from galvano-puncture performed for a relapse, the remainder from causes unconnected with the operation.

Dr. GARDNER asked if the bruit had quite stopped (Yes); and also if there had been any mention made of pulsation in the retinal veins in the recorded cases. (It was not stated.)

Dr. VESCO asked if it had been noticed after the operation whether the pulsation in the retinal vessels had disappeared. If the cause was due to a communication between the internal carotid artery and the cavernous sinus he should have expected the exophthalmos to have been in both eyes. In the sixty-five cases recorded the cause was given as fracture of the base of the skull. Considering the mortality of fracture of the base of the skull, and the absence of any evidence of it immediately subsequent, and the fact that the exophthalmos was only on one side, was it not more probable that the site of the injury was more anterior, and simply implicated the ophthalmic artery and vein.

Dr. GOSSE did not think that if the cavernous sinus was affected that there would necessarily be pulsation in both orbits, but as the cavernous sinus communicated with the circular, it was easy to understand how the pulsation might be transmitted to the opposite eye.

The report on Dr. Mitchell's case was then read.

NOTES OF A CASE OF EXTRACTION OF CALCULI FROM RIGHT LOIN.

By JAMES T. MITCHELL, M.B.

Read before S.A. Branch B. M. Association, July, 1884.

The patient, Mrs. B—, aged 46 years, has been a strong and active woman, but in June of the present year was very spare and excessively weak through years of suffering, which had almost worn the heart out of her. Her troubles began sixteen years ago with a uterine affection, probably diagnosed as some malignant growth, and a very bad prognosis was always given, and no treatment seemed to allay the symptoms, until at last, under the administration of chian turpentine, she made steady improvement. But no sooner had relief been obtained from this trouble than more severe pain in the region of the right kidney began to appear intermittently, and after the passage of a calculus, per urethram, ten years ago, she had two years respite from the colic. Obscure and various symptoms were considered by one or two of her medical advisers to point to some affection of the liver, and the excessive pain in the right hypochondrium seems to have been very marked even as long as twelve years ago.

For the last few years she had been under the treatment of a suburban physician for supposed renal colic, and had taken various preparations of opium, bromides, chloral, &c.

In November, 1882, she removed to the Semaphore,

and came into my hands during a most severe attack of colic. I gave pulv. opii. and hypodermics of morphia, and relieved her in about an hour. For six months she was attacked on an average every ten days, and then for six months more only twice a month, although gnawing pain in the right loin was constant. During the attacks the urine was heavily loaded with urates and sometimes phosphates, but there was no other change in it. The colic was of the most aggravated and agonizing character; her cries and groans were pitiful to listen to, although she was a woman of great self-control and seldom gave way to pain. She would be completely prostrated for thirty-six hours after each attack.

In October, 1883, the pain extended upwards, and right pleurisy set in, with an excessively irritating cough. Finally, much viscid and stinking mucous was expectorated for five or six days, but no pus was mixed with it. The loin and back up to the ninth rib were very tender, but no fluctuation could be distinguished.

On March 2, 1884, I aspirated above the 12th and 9th ribs, and midway between the last rib and the crest of the ilium. Nothing came by the needle, although the point evidently moved freely in a cavity at the two higher punctures. On the following day a large quantity of the same slimy fluid was again coughed up. The patient was then very low and weak, and her weight was under 95 lbs.; so I thought it inadvisable to attempt operation till she rallied up a little. By June 7 she was a shade stronger, although for four days previous she had been in almost constant, severe pain. Her weight had increased to 104 lbs.

The operation was therefore performed on that day under ether, without antiseptic spray, although everything was carbolized. I made an almost horizontal incision, keeping very near the edge of the twelfth rib and well back towards the end of the transverse process of the first lumbar vertebra. On reaching the mass of fat in which the kidney is embedded, I came into a cavity containing viscid fluid of a consistence and smell similar to that coughed up previously. Several calculi in a mass were discovered close to the upper end of the kidney. They were enveloped in a tough membrane which did not allow them to be widely separated from each other, and rendered their extraction somewhat difficult. Six calculi in all, of various sizes, were extracted, and one or two smaller ones could also be felt, but not grasped. They were faceted and polished, of dark-brown colour, with a few layers of white deposit between the brown layers, and they were soft enough to be scratched with the finger-nail. The specific gravity is about 1000, and the total weight of the six stones is 4.6 grammes (72 grains). One drainage-tube was put to the bottom of the wound, and a second one to the side of the colon which bulged into the outer end of the incision during the operation.

For the first few days the discharge was pretty free; but by the 9th day only a few drops exuded. From that time the quantity of discharge from the wound would barely saturate a double fold of lint.

Very local peritonitis supervened, and the temperature rose to 100° and 102.6° during the first week. The pain in the right side was very severe, but was relieved by hot turpentine enemata and fomentations, free doses of opium being given internally. On the 5th day the patient began to expectorate viscid fluid again tinged with blood, and this continued till the 8th day, when the right lung was full of soft, sonorous, and sibilant râles over all its extent. This continued until the 19th day, when she improved somewhat and the temperature fell to 99°. But on the 23rd day a

most intensely aggravating cough came on, and the right lung was discovered to be dull up to the 4th rib, the breathing hard and jerky below that line. From the 23rd to the 54th day (to-day) the temperature has varied about one degree above, and below 100°, and has never reached normal. The expectoration has been muco-purulent, and night-sweats have come on very many times.

The pulse, which varied from 120 to 140 during the first six weeks, is now about 110, rather small and fairly easily compressible. The wound has almost entirely healed, there being only the sinus an inch and a half deep, in which the drainage-tube lay till to-day.

An analysis of the calculi is being made, but is not yet complete.

SUPPLEMENTARY NOTES.—After the date of reading notes on the case (54th day), the patient gained strength somewhat, and was able to walk about from room to room, although the temperature varied from one to three degrees above normal. The lung symptoms cleared up, but a very irritating cough remained which prevented sleep. There was almost perfect freedom from pain till about the 75th day, when it came on severely again, and on the 77th day she was once more put under ether, and the wound opened up to allow the drainage-tube to be replaced. There was pretty free hæmorrhage at the time, and the urine for the next 36 hours contained many red blood-corpuscles. The sputa and vomited matters were also tinged and streaked with blood during the same period.

Urine now flowed freely through the drainage-tube and saturated the dressings, giving them a highly ammoniacal odour.

The pulse began to grow weaker and softer, and the patient became rapidly emaciated. Great pain was experienced on swallowing even minute quantities of food, so that at last everything but a little brandy and water was refused, and no nourishment whatever was taken for about four weeks before death, nor were the bowels moved during that time, although at first a variety of means were employed in the endeavour to open them. The pain continued, at intervals, very severe to the last, and the patient died on the 116th day after the removal of the calculi.

REPORT OF COMMITTEE.—The committee has met on two evenings (August 7 and 21), and on the second occasion Dr. Verco was unable to be present.

One member of the committee, Dr. Gardner, visited the patient with Mr. Mitchell, and found a transverse incision $3\frac{1}{4}$ inches long about one inch below the last rib in the right loin, the inner end being 3 inches from the spinous process of the vertebra. In the region of the gall bladder in front could be felt an ill-defined sense of resistance, which could be traced laterally to pass under the edge of the quadratus lumborum, and to end at the outer extremity of the incision. There was no enlargement of the liver, and the kidney could not be felt. Above the actual liver-dulness there was slight comparative loss of resonance in front and lateral regions, with a few râles. There was no jaundice nor any history of it. There is still a slight leakage from the inner end of the incision.

Mr. MITCHELL reported that, subsequent to the meeting, the patient was seized with severe pain in right hypogastrium, the temperature rising to 103°. This was followed by violent vomiting of a large quantity of mucous similar in consistence and smell to that which had escaped from the wound and the lungs.

The calculi were examined chemically and microscopically by the committee. They consist of

cholesterin and bile pigments. One floats in water, the others barely sink.

The committee is of opinion that the stones are of hepatic origin, and have probably found their way by a deep-seated fistulous channel to the right loin.

NOTES OF AUTOPSY.—Present: Drs. Verco, Thomas, and Gardner, and Mr. Mitchell. Dr. Verco performed the P.M., and Dr. Gardner took the notes.

On opening the abdomen the liver, which came two fingers' breadth below the ribs, was found to be adherent at points to the abdominal parietes, being connected by long, thin, and old adhesions. The liver edge was adherent to the omentum, and on separating it a small opening with ragged ulcerated edges appeared, down which a gum-elastic catheter was passed for several inches. On removing the sternum and costal cartilages, the lungs appeared very pallid. Slight pleuritic adhesions at back of apex of left lung. Right lung had a few slight adhesions. There was no communication between right lung and liver, or left lung and stomach. The extreme right side of the liver was adherent to the abdominal parietes at the last rib, and on separating this some purulent fluid escaped. Externally, at $3\frac{1}{4}$ inches from the spinal column, and between the last rib and the crest of the ilium was a transverse incision 2 inches long. The finger thrust through this penetrated into a small wound in the substance of the kidney. The ureter was then picked up at the brim of the pelvis and dissected carefully out till it ended in the pelvis of the kidney, which was not cut into. On passing the finger into the ragged opening under the edge of the liver, there could be felt upwards towards the median line a calculus, and downwards and backwards several other calculi could be felt. The ragged opening under the edge of the liver was then enlarged and found to lead into a large sinus from the gall-bladder to the spine. The remaining part of the gall-bladder was indicated by the presence of a calculus and the common duct was free throughout its extent. The whole of the right upper lobe of the liver was the seat of a large abscess lined with the usual pyogenic membrane. There was no communication between the kidney and surrounding organs. The wound in the kidney was opposite to that in the skin.

The conclusions to which your committee has come are as follows:—

1st. The committee are unanimous that the case was one of biliary calculi in a sinus.

2nd. That Dr. Mitchell, at the first operation, opened the sinus and removed several calculi.

3rd. That at a subsequent operation, Dr. Mitchell cut into the substance of the kidney, and that urine from that time flowed through the wound.

4th. That death was due to chronic pyæmia with formation of large abscess in the liver.

Lastly. Your committee have to express their thanks to Dr. Mitchell, for the care with which he has placed before them all the clinical details, and record their appreciation of the scientific spirit which has actuated him in assisting them to work out a solution of what was undoubtedly an intricate and extremely interesting diagnostic puzzle.

PATHOLOGICAL SPECIMEN.—Dr. Gardner exhibited a mass of lymphadenomata, which he had removed from the right side of the neck. Recovery. The growths filled up all the space between the ear and the clavicle. The external jugular vein was left untouched in a long strip of skin, two inches wide. After the dissection was completed, the lateral flaps were brought up and attached to the central flap.

NEW SOUTH WALES BRANCH.

The 47th meeting of the Branch was held in the Royal Society's Rooms, on Friday, 7th November, 1884. Dr. Quaife, President, in the chair.

Visitors: Dr. A. A. West, and Dr. Goode.

The President announced that Dr. Brady had resigned his seat on the Council, also his position as Hon. Treasurer, and in his place Dr. W. W. J. O'Reilly was elected member of Council and Hon. Treasurer.

Dr. Phillip Muskett read a paper on "Some Points in connection with the Small-pox Cases lately located at the Quarantine Station, North Head," which will be found elsewhere.

Dr. Hankins said, we must all thank Dr. Muskett for his very valuable paper. He (Dr. Hankins) had had some experience in small-pox, and always found that when the lumbar pains were severe the case was of a severe type.

Dr. Quaife said, he had listened to Dr. Muskett's paper with interest, as it brought to mind the time when he was attacked with small-pox in Edinburgh. He was taken ill on Monday; had no rigour; on the following Friday it was detected that he had small-pox. The principal points were headache, especially frontal, pain in the back in the dorsal region, and when the rash came out all other symptoms disappeared.

Dr. O'Reilly said, he did not quite understand from Dr. Muskett whether all the 13 cases were vaccinated. In a colony like this, where vaccination is entirely at the will of the people, he thought it would be interesting to know what effect vaccination had in these cases.

Dr. Muskett, in reply said, three were not vaccinated, the others had been vaccinated in childhood, and in the fatal case the man had been vaccinated in childhood, but not since. In the case of varioloid which occurred, he (Dr. Muskett) was certain that the case was modified by vaccination, the man was vaccinated five days before the attack.

Dr. Scot Skirving then read a paper "On the Treatment of Malignant Disease of the Tongue," which will be published in next issue.

Dr. M'Donagh exhibited a pathological specimen, and the meeting then terminated.

REPORT OF SOCIETIES.

ROYAL SOCIETY OF VICTORIA.

At the ordinary meeting of the above society, held on November 20, a paper by Dr. MacGillivray, M.A., of Sandhurst, on the *Reproduction of the Ornithorhynchus* was read by Mr. G. W. Selby in the unavoidable absence of the author. The paper said that the Bendigo School of Mines Science Society having offered a reward for females of the species procured in the end of October or beginning of November, several had been received, five of which he examined. Of these, two contained ova, two had given birth to young or ova, and one was unimpregnated. It had been recently announced that Mr. Caldwell, who was investigating the reproduction of the monotremata and ceratodus in Queensland, had ascertained that the ornithorhynchus was oviparous, and the ova meroblastic, but a full report of these discoveries had not been received. In the mean time all that was certainly known was that ova of the size shown had been found in the animal's uterus; that young of an inch to an inch and a half in length had been found in the nest, and that these were suckled by the mother. The intermediate stages of their development were absolutely unknown.

A lengthy discussion ensued, but no definite decision as to the method of reproduction of this interesting animal was arrived at. It was decided that Dr. MacGillivray's paper should be printed and circulated among the scientific societies, with the view of eliciting further information. The question would then again be considered, and it was hoped that at the next discussion the early life history of the ornithorhynchus would be cleared up.

MEDICAL SECTION OF ROYAL SOCIETY OF N.S. WALES.
An ordinary general meeting of the medical section of the Royal Society was held at the Society's house on the 21st November. In the absence of the chairman of the section, Dr. MacLaurin, the chair was taken by Dr. F. Norton Manning. The chairman read two papers communicated by Dr. Cosby Morgan, of Newcastle, and Dr. Eric Sinclair, of Gladestville, on cases of fracture of the skull. There was a fair attendance of members, and an animated discussion followed the reading of the papers. Professor Anderson Stuart showed a beautiful series of calculi from the University museum. Dr. M'Cormick, of the University, exhibited under the microscope sections of several tumours; and Dr. Jenkins, of Prince Alfred Hospital, also exhibited several interesting pathological specimens, the discussion which followed bringing to a close a more than usually interesting meeting.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

MacCarthy, Charles William, M.D., Bruxelles, 1884; M., 1883, L. 1873, K.Q.G.P., Irel.; L. 1873, F. 1884, R.O.S., Irel.
Wilson, John Clement, M.B., Lond., 1882.
Blyth, John Graham, L.R.C.P., Edin., 1883; L.R.C.S., Irel., 1880.
Orton, Arthur, M.R.C.S., Eng., 1883.

NEW ZEALAND.

Coleman, Alfred, M. et L. Mid., 1860, F., 1868, R.C.S., Eng.; L.R.C.P., Lond., 1868.
Will, William Johnstone, M.B. et Ch.M., Edin.
Martin, Albert, M.B., Lond., M.R.C.S., Eng., 1883.

QUEENSLAND.

Cole, Christopher Dillon Croker.

TASMANIA.

Mugliston, Henry Boyes, L. et L. Mid., R.C.P. et R.C.S., Edin., 1873; M.R.C.S., Eng., 1871; L.S.A., Lond., 1870.

VICTORIA.

Allen, William Robert, L. et L. Mid. R.C.P. et R.C.S., Edin., 1882.
Eakins, George Reginald, L.R.C.P. et R.C.S., Edin., 1883; M.D., Brussels, 1883.
Faskally, George Bleock, L.S.A., Lond., 1874; L.R.C.S., Edin., 1874; F.R.C.S., Edin., 1876.
Morton, Francis William Watson, L. et L. Mid., R.C.P. et R.C.S., Edin., 1880.
Travers, Geoffrey Frederick, M.R.C.S., Eng., 1882; L.R.C.P., Lond., 1883.
Weber, Johann August, Netherlands States Exam., 1876; M.D., Giessem, 1876.

Additional Qualification Registered:

Wyer, Charles Eakins, F.R.C.S., Edin., 1881.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, DECEMBER 15, 1884.

EDITORIALS.

THE CASE OF GREEN v. EMBLING AND YOUL.

THE case of Green v. Embling and Youl, recently tried in Melbourne, shows to what vexation, annoyance, and expense medical practitioners may be put as a consequence of the imaginary injuries suffered by a valetudinarian police officer. Drs. Embling and Youl, in the exercise of their duty as members of the Police Medical Board of Victoria, examined the plaintiff, a superintendent of the police of that colony, and in consequence of the impression formed in their minds as to his mental state, certified that he was unfit to perform the duties of his office, and he was, consequently, superannuated. He on this commenced an action for damages against them on the ground that their examination was conducted without due care, and that their adverse certificate was given from malice towards him. We think that the evidence given, that at his interviews with the Board and the Chief Secretary he burst into tears, is, without anything else, sufficient to justify the course they took, for a crying policeman is a phenomenon which it would not be well to continue in the public service. As to the charge of malice, it is one which is often made, but generally nothing but the inordinate self-conceit of the supposed victim gives even the slightest air of probability to it. Drs. Webb, Beaney, and Blair gave evidence that in their opinion the plaintiff was not suffering from illness which disqualified him from acting as police superintendent, but their opinion seemed to relate more to his physical than to his mental state. The verdict was of course for the defendants, to whom we tender our sincere sympathy.

THE OVER-CROWDED STATE OF THE PROFESSION IN AUSTRALIA.

THE number of applicants (sixty-three) for the office of Medical Officer to the benefit society connected with the Australian Agricultural Company's Collieries, shows that there is no scarcity of medical men in New South Wales, or indeed in Australia generally. These colonies have of late years acquired a reputation as the "Eldorado" of the profession, but this, if it ever were the case, cannot be so longer, if the present enormous influx of recently fledged doctors continues. To avoid sad misfortune and disappointment, we can but recommend young practitioners, without some friends or connections in the colonies, to hesitate before they rush out here, except it be that they have some private means to keep them going for a year or two. If this is the case now, what will it be in a few years' time with the Melbourne and Sydney medical schools at present in full work, with the Adelaide one to be shortly started, and with the numerous young men of Australian birth at present studying in Europe and America with a view of settling in practice here.

THE PROSECUTION OF DR. DONOVAN.

THIS medical practitioner was, on December 11, convicted under the Infectious Diseases Supervision Act of New South Wales for having omitted to report to the health authorities in Sydney that a patient under his care was suffering from small-pox. He was ordered to pay a fine of £50 (the highest penalty), with costs, to be recovered by levy and distress, failing such recovery to be imprisoned for three months. Notice of appeal was given. There are three more similar charges against him which are to be heard on December 16. As these cases (the first being under appeal, and the others being untried) are *sub judice*, we refrain from comment in this issue.

ST. VINCENT'S HOSPITAL, SYDNEY.

WE are informed that, in consequence of an abrupt departure from established custom in the appointment of new members of the honorary medical staff of this hospital, the whole of the consulting and active honorary physicians and surgeons, with the exception of Drs. Clune and McCarthy (only just appointed), have resigned their offices.

DR. MONCKTON AND THE KUMARA HOSPITAL COMMITTEE.

WE have received copies of the *Kumara Times* (N.Z.) containing the report of a Hospital Committee Meeting on November 25. It seems to have been specially summoned to consider complaints made by some one or two mal-contented against the surgeon of the Institution, Dr. Monckton. There appears to have been no complaint, or ground for complaint against the professional conduct of this gentleman, but only as to his manner towards some apparently well-to-do people (amongst them a member of the Committee), who, having a fitting consciousness of their personal value, are careful to obtain medical and surgical treatment at the hands of the hospital surgeon for a shilling "a go" at which rate some absurd rule of this hospital authorises ticket-holders to demand it. Dr. Monckton appears to be something of a colonial Abernethy, giving every individual who applies to him, his best and most skilful professional services, but at the same time openly showing the contempt he feels towards the delectable crowd he has to deal with. This is certainly honest, but of questionable policy, when dealing with persons such as the newspaper report shows the majority of this Hospital Committee to be. The complaining individuals, it is apparent, are only too pleased to be able to harass and annoy a man, their superior in social standing, moral worth, education and generosity, and naturally do not miss the opportunity. The chairman, if the report is correct, is a plastic individual whose opinions are to be moulded as "the butcher, the baker, and the candlestick maker," forming the majority, may desire. We sympathise with Dr. Monckton, and consider that should his connection with the hospital cease, the loss will be not his, but the patients' whose well-being, it is unanimously acknowledged, he constantly made his study.

SMALL-POX PROSECUTION IN MELBOURNE.

THE prosecution of Mr. Eyton, saddler, of Queen-street, Melbourne, for neglecting to report the existence of small-pox in his house, failed to result in conviction, the case being dismissed by a majority of the bench. We are of opinion, judging from the evidence as published in the *Argus*, that a miscarriage of justice has occurred, and that the public interest has suffered. We think that cases of this kind should be only tried by a stipendiary magistrate sitting alone, and not by a number of justices sitting or not sitting at their own sweet will, many of whom may be intimate friends of the accused.

SMALL-POX COMPENSATION IN VICTORIA.

TO the other lamentable oversights, differences of opinion, and negligences in the treatment of the outbreak of small-pox in Victoria, the Government of that colony have added the very grave mistake of allowing an uncertainty to arise as to the payment of compensation for bedding, &c., destroyed as infected, by order of the health authorities. The dispute being whether it is to be paid for by the Central Government or by the local Board of Health of the district in which such destruction has been ordered. We fear that this will lead to carelessness, or perhaps even to intentional neglect in the destruction of infected goods, so that the prospect of the stamping out of the plague will become more distant than ever.

THERE seems but little uniformity in the grants made by the New Zealand Government in aid of charitable institutions in that colony. The hospitals wholly maintained by the Government are, generally speaking, those at the chief centres of population (though in the Canterbury districts all the Hospitals are so maintained), whilst those in country districts are maintained on the system of subsidies of £1 for every £1 subscribed by the general public or the local bodies for the support of the hospitals. There are a few exceptions to the pound for pound rule. The Tuapeka hospital has had £3 for £1 and the Waipawa County and Coromandel hospitals have had £2 for £1, whilst at Patea half the actual cost is refunded by the Government to the local bodies who manage the hospitals. The revenue derived from the hospitals maintained wholly by the Government, which consists of payments by patients, public subscriptions, and miscellaneous items (such as sale of pigs, &c.), amounts to about one-fifteenth of the expenditure. The hospitals, except in Wellington, are managed by committees variously chosen. Of those maintained by Government, that at Auckland is managed by a committee, half of whom are elected by those who subscribe £306 against an expenditure of £6575, and the other half are nominated by the Government. We think that the Government should be represented on the committees of these institutions somewhat better, relative in a proportion to the subsidy given.

DURING the last few weeks a most extraordinary series of fatal cases of peritonitis, following criminal abortion, has taken place in Sydney. They are no less than five in number, and though in each of the cases the uterus was perforated by the clumsy operator, it is probable that the death was consequent on septicæmia from infection by dirty non-disinfected instruments. Two chemists, named Sheridan and Thomas, have been committed on charges of murder, and are now in gaol awaiting their trial. We refrain from further comment until after this has taken place.

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WE have received a copy of the *Forbes Times*, containing a short article relative to the case against Dr. Eichler for neglecting to report cases of small-pox, to which charge he pleaded guilty, and was fined in the lowest penalty. The writer, with the usual omniscience of editors of country newspapers, seems to think that a miscarriage of justice has taken place, in consequence of no prosecution having been instituted against the doctor at Forbes who reported a suspicious case resembling variola as existing in that town. We have studied a most careful and accurate report of this case by the inspecting medical officer, and are of opinion that the practitioner, or rather practitioners (for the Government Medical Officer of the district when called also expressed his opinion that the case was so suspiciously like small-pox as to require isolation) but acted properly, and in the public interest, when they treated it as they did. Not only did they not deserve to be prosecuted, but they fairly earned public commendation for their action, for if an error in judgment is to occur, it is very advisable that it should do so on the side of caution. A case of measles, in the early stage of eruption, often so closely resembles the papular stage of variola as to require at least twenty-four hours suspension of judgment for the most experienced practitioner to decide positively which disease it is. In addition, we would point out to this rural Solon that no Act exists under which the doctor's action constitutes an offence, and that even if it did, nothing would be more impolitic than to act on it.

FROM the *Journal of Mental Science* we learn that at a meeting of the Medico-Psychological Association, held at the Royal College of Physicians, London, on July 23rd, 1884, the following gentlemen were elected honorary members of the Association, namely, Dr. Curwen, of Philadelphia, Secretary of the Society of Superintendents of American Asylums; Dr. F. Norton Manning, of Sydney, Inspector-General of the Insane in New South Wales, and Dr. Workman, late Medical Superintendent of the Chief Toronto Asylum, Canada.

We are very pleased to see Dr. Manning's name in this list, not only because he is the representative Psychologist of the Southern hemisphere, but also because his election must be considered a compliment to Psychological medicine in Australia, especially as the number of *Honorary* members is so small, and this, we believe, is the first time that any one in Australia or Canada has been appointed.

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IT is hard to see what public good will result from the publication of a letter signed William S. Cortis, M.D., in the *Sydney Daily Telegraph* of December 12, but it is not so doubtful as to the harm which may arise from it in so far, as it without just excuse may again raise doubts in the lay mind as to the unanimity of the professional men of Australia in their opinions as to the present outbreak of small-pox. Its diction is so involved as to very considerably puzzle its readers as to what the writer intended to say. Immediately after speaking of small-pox, he goes on to say—"In the latter disease this eruption continues in the state of papulæ for six or seven days, when it develops into pustules." Does he mean that *small-pox*, after continuing in the papular stage for six or seven days, becomes pustular, thus, contrary to all known precedent, spinning out this phase which lasts from twenty-four to forty-eight hours to the unconscionable length of six or seven days, skipping the vesicular period altogether, for he most assuredly *says* this? If he does, his knowledge of the pathology of variola is woefully erroneous, whilst if he does not, but intends his very peculiar description to apply to "*Rötheln*," then his grammar is unutterably worse, and according to all authorities, his pathology equally bad. We do not care to weary ourselves more in attempting to elucidate the object of this very unprofessional letter, except to indulge in the supposition that it is intended to inform the people of New South Wales that "the unusually practised eye" was, by the beneficence of Providence at this critical period in Coonamble, and that "a member of the Metropolitan Asylums Board" is at present in Australia.

LEADING ARTICLE.

APOMORPHIA.

BY CHARLES JAS. DEVIS, M.R.C.S., ENG., &c.,
SYDNEY; LATE SURGEON TO THE CHARTERS
TOWERS DISTRICT HOSPITAL, QUEENSLAND,
AND FORMERLY RESIDENT SURGEON TO THE
HEREFORD (ENG.) INFIRMARY.

AFTER the unfavourable comment upon Apomorphia, made by Dr. Bancroft, in the September number of the *A. M. G.*, it was with considerable satisfaction that I read Dr. Thompson's article in support of that valuable drug in the October issue.

During two years of active practice in Queensland, it was my custom to carry apomorphia with me as constantly as my hypodermic syringe and morphia, and not a few times have I had cause to be thankful I did so; in fact, so accustomed was I to use this drug, that when obliged to superintend the administration and action of an emetic I have rarely used any other. As an emetic I have found it surpass in certainty, rapidity and effectiveness of action any other drug with which I am acquainted. Moreover, I have found it produce emesis in a few minutes, where ordinary emetics utterly failed; and in cases where swallowing from one cause or another has been impossible, or where the administration of drugs per mouth has been combated by the patient, the subcutaneous injection of apomorphia has proved invaluable. In the comatose stage of alcoholism, where no reaction to even violent stimuli can be obtained, and again where violent delirium—I do not speak of D.T.—is present, alcoholic fluids having been recently taken, when neither emetics can be given by mouth nor in the latter condition the stomach tube be used, except by the aid of considerable force, in such cases the marked improvement produced by the apomorphia in emptying the stomach, has been a source of astonishment to the bystanders, and congratulation for interested parties upon hysterical and malingering individuals when the conspicuous phenomena have consisted of constant and violent but ineffectual efforts at vomiting, apomorphia has acted as a charm. Another class of cases where I have found this drug useful is that of pulmonary catarrhal conditions, particularly in

children, where the accumulating secretion in the bronchi produces a state of ever increasing asphyxia. As is frequently the case, the usual emetics are administered with almost or quite no effect, but on the contrary, from their presence in the stomach in considerable quantities, do harm; in these cases apomorphia acts quite readily, whether previous emetics have been administered or not, but usually only once or twice, and here I think we encounter a drawback in the use of this drug, for in these cases more benefit would be obtained by repeated moderately violent attempts at vomiting, which would do more towards clearing the air passages of the secretion, and dilating collapsed patches of lung tissue than would the one or two slight efforts followed by one violent emesis of which the action of apomorphia usually consists. In cases of poisoning, where emesis is necessary, and the use of apomorphia not contra-indicated, this drug, from its rapid and complete action, is of the greatest value. It has fallen to my lot to use it in three such cases. One was suicidal poisoning by a concentrated hot water solution of oxalic acid in which vomiting was produced, but not before severe injury had been done to the stomach, considerable hæmatemesis and great collapse resulting. A second case was one of wholesale poisoning by tinned fish, in which severe gastro-enteric catarrh was rapidly induced. Out of a family of eight, six of whom presented symptoms, I administered the apomorphia to three, and in a short time afterwards had the pleasure of seeing them comfortably sleeping, whilst those to whom I did not give the drug were exhibiting symptoms much longer. The third case was one in which a child, some three years of age, had swallowed part of a bottle of liniment containing opium—viz., Lin. Saponis with a proportion of tinct. opii. In this case the apomorphia was administered within ten minutes of the taking of the poison, which produced no symptoms beyond contraction of the pupils, the short slumber which followed the emesis I do not regard as a symptom produced by the poison, as it is usual after the administration of apomorphia. I am not prepared to say that symptoms of any severity would have appeared had no precautionary treatment been adopted, for there was a little difficulty in ascertaining the amount of liniment that had been swallowed.

This case is of some interest, as it deals with a question arising out of Dr. Bancroft's comment, namely, whether apomorphia produces narcotic symptoms in the human subject similar to those of morphia narcosis. I have never met with dangerous symptoms after the administration of apomorphia, but have once or twice seen an

unpleasant amount of depression follow its use. As a rule, after the hypodermic injection of the drug at the end of from two to four minutes, perspiration, an uneasy feeling at the epigastrium, dizziness and faintness come on, the pulse becoming softer, more compressible and sometimes dicrotous; this is rapidly followed by one or perhaps two feeble attempts at vomiting, and then all at once a successful effort is made, which is rarely repeated more than once. The patient then usually falls back somewhat exhausted and sleeps for a short time. In two instances under my notice the nausea and vomiting lasted for some hours, occurring with each effort to sustain the upright position, in these cases the depression was more severe, and lasted for a longer period. In both cases the drug was given for migraine, and was only partially successful in stopping the attack. In no case have I seen symptoms of narcosis similar to those produced by morphia, not even in young children.

I may, therefore, sum up by saying that after considerable experience in the administration of apomorphia as an emetic, I see no contra-indication to its use in any case where rapid emesis is required, except perhaps where cardiac depression is already present to a considerable extent, and I believe that even then the drug might be used, provided the judicious administration of a stimulant be at the same time adopted and the recumbent position strictly enjoined. I have always used a hypodermic solution prepared from the gelatine discs at the time required, and the dose I have given has varied from 1/60th of a grain for infants to 1/10th of a grain for adults, and only on one occasion had I to give a second dose to procure vomiting.

Mr. J. T. Harcourt, proprietor of the well-known private retreat for the insane and inebriate at Cremorne Gardens, Richmond, near Melbourne, has disposed of this property, owing to his health not being equal to the strain of management, he now being over 70 years of age. Mr. Harcourt, for many years proprietor of Hunningham and Harbury Hall Lunatic Asylums, in England, established the above private Asylum at Pasco Vale, in 1856, and transferred it to Cremorne Gardens about 1863. As the purchasers intend to subdivide the site, about 13 acres in extent, and to place it upon the estate market, we presume the institution will not be carried on. If so, the Cook's River private asylum, near Sydney, will be the only one in the whole of Australia where patients can be accommodated except in the large Government institutions. This asylum is now under the able management of Dr. A. J. Vause, and, we believe, compares favourably with the best European institutions of the kind.

THE MONTH.

NEW SOUTH WALES.

At the November meeting of the Senate of the Sydney University the following recommendation of the Board of Studies was adopted:—"That Mr. Haswell's title be 'lecturer on zoology and comparative anatomy and demonstrator in histology,' and that the duties of his office be those which are indicated by his title."

The plans for the new Medical School, which had been prepared by the Colonial Architect, were submitted to the meeting, and, after due consideration, were approved. It was resolved that an application be at once made to the Government for a sufficient sum of money for the completion of the building.

In compliance with an application from Professor Dr. Anderson Stuart for a definition of the tenure of his office, it was resolved that Professor Stuart be informed that the tenure of his office is "during good behaviour."

At the December meeting of the Senate of the Sydney University a communication was received from the Sydney Hospital, in which it was stated that the house committee of that institution had nominated Dr. C. D. Clarke as clinical lecturer in Medicine, Dr. H. Tarrant as lecturer in Clinical Surgery, and Dr. Cecil Morgan as lecturer in ophthalmology. The selection was approved on the motion of the Dean of the Faculty of Medicine. At the same meeting the following gentlemen were appointed assessors in the first professional medical examination to be held this month:—In Botany, Professor Stuart (in the absence of the examiner, Baron von Müller), Mr. W. A. Dixon, in chemistry, and Mr. J. J. Fletcher in comparative anatomy and zoology.

THE report of the board appointed to inquire into the advisability of wood-paving for the streets of Sydney has been laid before Parliament. The board are of opinion that wood is a material which cannot safely be used for paving the streets unless it can be rendered absolutely impermeable to moisture. The board consider that asphalt is the most suitable material, and that pavements formed of it more nearly approach what a model pavement should be than those made of any other material. A discontinuance of wood-paving in Sydney is recommended.

CORONIAL inquiries were lately held in Sydney into the deaths of four women who died within one week, it is alleged, from an attempt on the part of T. M. Sheridan, a chemist, to procure abortion. The medical evidence in each case went to show that two purple spots were observable on the pregnant uterus, and on further examination it was evident that its fibrous covering had been wounded, and that the cause of death was from collapse, following acute peritonitis, the result of the penetrating wound of the uterus. In three cases a verdict of wilful murder was returned against T. M. Sheridan and his employers, who were concerned in those cases, but in the fourth case the jury was unable to agree, and the papers relating to it were forwarded to the Attorney-General for his consideration.

At the Sydney Water Police Court, on December 4, Evan Thomas, a chemist, was charged with having administered a certain drug to a woman named Ada Hughes, for the purpose of bringing on a miscarriage, on or about the 23rd of June last, together with T. M. Sheridan, the chemist, who has been committed for trial in connection with other cases. After the evidence for the prosecution had been taken, the prisoners were committed for trial at the next sittings of the Central Criminal Court.

ELEVEN fresh cases of small-pox in Sydney and suburbs were reported during the last few days in November.

AN Act has been passed by Parliament authorising the sale of the site of the Goulburn Hospital, and providing for the expenditure of the money received therefrom in the erection of suitable buildings for a like purpose on a new site.

DR. G. WISTON BAKER, formerly of Fiji, and late of Summer Hill, has been elected medical officer to the A. A. Co.'s Collieries, Newcastle. There were not less than sixty-three applicants for the vacant position, which number was reduced to thirty-three on the day of election. The names were:—S. A. Alcorn, J. K. Barnett, A. C. Brownless, G. M. Black, J. W. Cox, J. Clifford, W. Ewington, B. B. Floyer, H. Finlay, H. Foord-Clark, H. Friedman, J. Graham, S. Hammond, J. Hill, H. L. Harris, J. Inglis, A. Johnston, J. P. Kealy, J. W. Kennedy, T. W. Lee, W. M. Murray, W. Middleton, M. D. Murphy, — McMillan, A. Orton, J. Protheroe, George Read, Henry Read, C. H. Smith, J. C. Souter, T. H. Tennant, and Dr. G. W. Baker, the successful candidate.

DR. T. B. BELGRAVE has removed from Market-Street to 60 Castlereagh Street North, Sydney.

DR. L. BERNSTEIN, of Lismore, has been appointed a coroner for the colony generally.

DR. A. FORBES, late of Walgett, has commenced practice on the Tweed River, in a sugar-growing district, near the Queensland border.

DR. C. HEDLEY, a graduate of the Melbourne University, has settled at Brushgrove, a post town on the Clarence River, 338 miles north of Sydney.

DR. THOMAS CHARLES HOWE, M.B., 1868, M.D., 1869, Toronto, Can., late of West Maitland, died at Maximus Terrace, Glebe-road, Sydney, on November 28, at the age of 36.

DR. C. W. MCCARTHY has commenced practice at 20 College-street, Hyde Park, Sydney.

DR. CHARLES M'KAY, of Church Hill, Sydney, has removed to his private residence at Rooty Hill, about 25 miles west of Sydney.

DR. A. W. MCMATH has commenced practice at Dungog, on the Williams River, in an agricultural district 130 miles N. of Sydney.

A CAB, containing Dr. Rowling and his son, was overturned in Church-street, Parramatta, on November 19, owing to a van having run into it. The doctor and his son escaped unhurt, but the cab-driver was slightly bruised by his fall, and the vehicle was considerably damaged.

DR. E. FAIRFAX ROSS, a native of Sydney, who has just returned from England, has commenced practice at 145 Macquarie Street, Sydney.

DR. W. G. WATSON, late of Bombala, has commenced practice at Croydon, a suburb six miles from Sydney.

DR. LAUCHLAN HECTOR JOHN MACLEAN, who died in Sydney on October 10th, was born in the Madras Presidency of India in 1828. He was the second son of John Guy Maclean, lieutenant in the East India Company's service. At a very early age he left India, and was educated at Inverness, Scotland; he then visited this colony, and after a short stay he returned to Europe and commenced his medical studies at the Charing Cross Hospital, London, and obtained, in 1853, the membership of the Royal College of Surgeons of England. After going through another examination,

he was appointed assistant-surgeon in the East India Company's service, and arrived in India in 1854, when he was appointed to the Horse Artillery, with which corps he remained through the whole of the Mutiny in 1857, in the Punjab. For his services during three cholera epidemics in India he was thanked each time by the Governor-General in Council. In addition to his military duties, he had charge for many years of the Civil station of Amretsin, where he remained until 1863, at which period he again visited Sydney and Tasmania on sick leave. He returned to Calcutta, but shortly afterwards left for Europe, and retired from the service. After a long residence on the Continent, where he obtained the degree of M.D. of Heidelberg, in 1866 he went to London and passed the necessary examinations to enable him to become a member of the Royal College of Physicians of London, and shortly after came out to Sydney. In 1883 he was admitted *ad eundem gradum* to the M.D. of the University of Sydney. In 1882 he became honorary physician of St. Vincent's Hospital, and was zealous in the performance of his duties to the invalids in that establishment. His end was hastened by too close application to these duties, and he may be said to have died in harness, working up to the very last.

NEW ZEALAND.

THE Christchurch Hospital Board has decided to make an effort to erect an infectious diseases ward at a cost of about £1000, one half of this sum to be raised by subscription, the other half the Board hope to obtain from Government.

A FIRE occurred at the Dunedin Hospital on the afternoon of October 25, which, fortunately, was extinguished before any serious damage was done. In view of any such accident, the wardsmen are drilled in the use of the fire-extinguishing appliances.

DR. W. COTTERELL, of Asaph-street, Christchurch, has removed to his new house in Manchester-street, and will commence practice about the 25th December.

DR. P. B. TRIVY, late of Christchurch, has removed to Hokitika, the capital of the province of Westland.

DR. W. J. WILL, a new arrival, has settled at East Taieri, Province of Otago.

QUEENSLAND.

AT a meeting of the Central Board of Health, held on November 21st, Dr. Bancroft raised a discussion regarding the water supply as affecting the health of the people, and it was ultimately resolved that the secretary should apply to the Colonial Secretary's department for all information regarding the water supply of the various districts at present under the operation of the Health Act.

MR. MORLEY EDDISON CLOUGH, L.R.C.P., Edin., et M.R.C.S.E., 1881, who for the last nine months practised at Gympie, died last month.

DR. C. D. C. COLE, a new arrival, has settled at Maryborough.

DR. W. B. KIRKALDY, a new arrival, has settled at Charleville, on the Warrego River, in a pastoral district 520 miles west of Brisbane.

DR. R. W. LETHBRIDGE, who for the last twelve months has been practising at Gayndah, has left this district.

DR. GASPARE SPELLINI has settled at Maytown, the centre of the Palmer goldfield, 1150 miles N.W. of Brisbane.

SOUTH AUSTRALIA.

MR. ROBERT WATERS MOORE, M.R.C.S., Eng., 1842 President of the S. A. Medical Board, Hon. Consulting Surgeon to the Adelaide Hospital, and member of the Board of Visitors to the S. A. Lunatic Asylums, and formerly Colonial Surgeon, died at Adelaide on December 6, at the age of 65 years.

DR. E. ELPHICK, of Moonta, has removed to Maitland, the centre of a wheat-growing district on Yorke's Peninsula.

DR. MORICE, Colonial Surgeon in the Northern Territory, has been suspended from the office of Protector of the Aborigines for alleged wilful contravention of the Government instructions respecting the Daly murders.

VICTORIA.

ON Saturday, December 6, the Council of the University of Melbourne, under the presidency of the Chancellor, Dr. Moorehouse, Bishop of Melbourne, conferred the degree of Bachelor of Medicine upon Messrs. L. J. Birch, W. J. Bird, G. Horne, A. S. Joske, C. G. Kent, H. F. Main, C. H. Mollison, W. P. Murphy, N. M. O'Donnell, J. McL. Pardy, E. Ryan, and *ad eundem*, George Rothwell Wilson Adam; and that of Bachelor of Surgery upon Messrs. George Horne and C. A. Altmann.

THE Government have decided to continue the present Central Board of Health arrangements till the end of June next, and then the operations of the Public Health Act of last session will be reviewed, so as to see to what extent amendments are necessary. A bill for the amendment of the lunacy law has been drawn up by Mr. A. Beckett, embodying most of the suggestions of the progress report of the Lunacy Commission. It will be introduced into Parliament this session, and an endeavour will be made to pass some of its clauses if time does not admit of the whole.

DURING the month of November, 1,064 points of calf lymph were received at the office of the Central Board of Health from the Calf Lymph Depot, 983 points were distributed to the various public vaccinators, and the number of cases vaccinated at the depot was 67. So far as could be ascertained, the vaccinations were almost uniformly successful.

AN application has been received by Central Board of Health from the Sydney Health authorities for 500 tubes of humanised lymph, a portion of which has been supplied, and the remainder will be forwarded as soon as possible.

AT the meeting of the Lunacy Commission held on November 27, Dr. McCreery, medical superintendent of Kew Asylum, expressed his opinion that, if there were an asylum for quiet, harmless cases, about 70 male and 60 female patients could be sent to it from the Kew Asylum. Most of these were paralysed, broken-down cases—more fit for the Benevolent Asylum than a lunatic asylum. He also pointed out that in the course of a report which he prepared in 1883, he made some suggestions which he now considered worthy of the consideration of the commission. He had proposed that warrants for the detention of persons in a lunatic asylum should be for a definite period, after which they would expire, and if further detention were thought necessary, a new warrant would have to be obtained. This would insure the consideration of each individual case at certain periods, and remove any chance of patients being passed over and forgotten. The medical superintendent and a medical member of the board of

visitors could certify, and so avoid unnecessary expense.

AT a meeting of the Executive Council on December 2, Surgeon-majors Gillbee and Bone were placed on the retired list, and Surgeons J. P. Ryan and E. Hinchcliffe were promoted to the rank of surgeon-majors.

THE sanatorium at Cut-paw-paw is now clear of small-pox patients, the last of them left there on November 11. The staff has been reduced, but Dr. Coutie and a few nurses will remain there for some time longer, so as to be ready in the event of any fresh cases breaking out.

AT a recent meeting of the Melbourne Hospital Committee, the secretary remarked that complaints of discourtesy had been made against some members of the medical staff, and it was decided that he should advise them that, as their conduct had been brought before the committee, it would be well for them to improve their behaviour.

THE recently erected convalescent cottage on Brighton Beach, in connection with the Melbourne Hospital for Sick Children, was opened on December 2.

A FINE of £20 has been inflicted on a man named Pitt, at Newstead, for neglecting to report to the health officer of the district that chicken-pox was prevalent in his family.

AN action brought by Mr. Reginald Green, late superintendent of police, to recover £3000 damages from Drs. W. H. Embling and R. Youl, members of the Victorian Police Medical Board, for certifying that he was incapacitated by ill-health from attending to his duties, whereby he was superannuated, was commenced at the Supreme Court, Melbourne, on November 20, and concluded on the 22nd November, a verdict being returned for the defendants.

The annual *conversations* of the Microscopical Society was held in the Hall of Pharmacy on November 27. A large number of ladies and gentlemen were present by invitation. During the evening, Dr. Ralph, president of the society, lectured on protoplasm and the development of the vegetable cell. Mr. C. R. Blackett spoke on "The Microscope and its useful application."

An epidemic of whooping cough is raging at Wandiligong, the state school there being almost deserted by its pupils. One death from whooping cough is reported.

MEASLES have made their appearance in the Shepparton and Murchison districts.

Dr. W. R. ALLEN has settled at Ballarat, and Dr. G. R. Eakins at Echuca; both gentlemen are new arrivals in the colony.

DR. DAVY, of Malmesbury, has, it was reported at a recent meeting of the Royal Society, been elected an honorary member of the Royal Society of Electrical Engineers.

DR. J. W. HARRISON, medical officer of the erysipelas ward in the Melbourne Hospital, has resigned.

DR. W. H. OWEN, late of Warrnambool, has returned to the colony from his trip to England, and has now commenced practice at 4 Bank Street west, South Melbourne.

DR. DUNCAN TURNER, late of Moonee Ponds, having disposed of his practice to Dr. James Campbell, has removed to 115 Collins-street East, Melbourne.

DR. W. F. MILLER has succeeded to Dr. Campbell's practice at Maryborough.

CORRESPONDENCE.

CORONERS AND MEDICAL ETIQUETTE.

(To the Editor of the A.M.G.)

SIR,—May I beg the favour of a reply to the following statement and question? A is called at 2 a.m. to see a patient. He arrives at the house in less than ten minutes, and finds the man dead about two minutes. A wishes to make a post mortem, but in the morning at 10 a.m. an inquest takes place, and B (A's rival practitioner), who is Government medical officer, is called in, and ordered to perform the post mortem. Now, Sir, post mortem examinations are scarce in the country, and a medical man seldom performs one without learning something new. Therefore, I would ask is it fair because B is Government medical officer that the coroner should pass over A completely, and place the case in the hands of B?

Faithfully yours,

R. T. A.

[We are of opinion that in the case mentioned by our correspondent, A, the medical practitioner who saw the body shortly after death, should have been directed to make the post mortem examination required, and that the coroner who directed another practitioner to do it showed but a poor knowledge of the duties of his office, and exhibited great want of courtesy to the profession generally. The rule which should be followed is this: That where an inquest is necessary on a case which has been seen shortly before or just after death by a legally qualified medical practitioner, always supposing that his conduct of the case has not been called in question, he only should be directed to make the post mortem examination. It must not be forgotten, however, that the coroner has a legal right to direct any qualified practitioner he chooses to perform this duty, and, that all other things being equal, the Government medical officer is the one he should employ.—ED. A.M.G.]

FEES TO MEDICAL WITNESSES.

(To the Editor of the A.M.G.)

DEAR SIR,—I notice in your last issue a letter from Dr. Johnston on the above subject, which I should like to supplement with a few remarks of my own.

Last week I was requested by the local police officer to give evidence at a magisterial inquiry, on the body of a man who had committed suicide by cutting his throat, the inquiry being held at the residence of the deceased, about seven miles distant. I attended and was detained there four hours, the detention being caused principally by the J.P., who, either through unwillingness or inability to examine the witnesses, requested me to undertake that part of the inquiry. When I proceeded to fill up the form required by Government for a statement of fees, I found myself entitled to the magnificent remuneration of £1 ls. for my evidence, and 1s. 6d. per mile one way, making a total of £1 11s. 6d. Even putting aside the time wasted on the inquiry, how can such a fee requite a professional man for travelling fourteen miles with all the wear and tear of horses, buggy, &c.? I shall be glad if some further notice is taken of this subject, which may lead to a revision of the scale of fees as it at present stands.

I am, &c.,

HENRY C. JEE, M.R.C.S. &c.

Mount Wycheproof (Victoria), Nov. 24th, 1884.

QUACKS AND THE PHARMACEUTICAL SOCIETY OF N.S.W.

(To the Editor of the A. M. G.)

SIR,—The report in your issue of November 15th is re inquest on the body of Agnes Rochford, I desire briefly to state that the witness, T. H. Clarke, was admitted a member of the Pharmaceutical Society of New South Wales from the fact of his having kept open shop, calling himself a chemist, before the Society was formed, and therefore his application for membership had to be granted.

I trust, Mr. Editor, that considering the circumstances and the care and anxiety exercised by the Society for years, to cultivate knowledge by lectures, by their well-selected library, and in other ways, you will not fail to see that the Society is not censurable for having admitted one who could not have been excluded.

I may remark that the Council of the Pharmaceutical Society have been for some time urging the Government to pass an Act, whereby none but *qualified* persons would be allowed to deal in or dispense medicines, and your pen might help their efforts. I am, yours, &c.,

Dec. 11, 1884.

W. T. PINHEY, Secretary.

[We certainly do not consider this *explanation* of the Secretary of the Pharmaceutical Society a satisfactory one. Some particulars as to the application made, the names of the persons recommending, might, without any very great stretch of courtesy, have been given for the information of our readers. We think the applicant was a man, who, upon his own evidence, was so unfit to be allowed to pose before the public as a member of the Pharmaceutical Society, that the governing body of that corporation might have fairly declined to accept him until he compelled them to do so by an action at law. The explanation which has been so tardily and inefficiently rendered to us, is likely, however, to be more promptly and properly given to the public now it has been demanded by the lay press at our suggestion.—ED. A.M.G.]

MINOR NUISANCES.

(To the Editor of the A.M.G.)

SIR,—I believe we hear more often of medical practitioners suffering from Insomnia than is to be found proportionately among other people, and this I feel certain, is due more to petty irritations than to great anxieties; some of these we have to put up with as irremediable, but there are others which proceed from certain ministers of religion which exposure may lessen. Two descriptions will suffice, I think, to make nearly every practitioner say "I've met one!"

The first is the curate (generally a chronic invalid or hypochondriac) who peregrinates with a waistcoat-pocketful of homoeopathic globules and a Vade Mecum in his hand. He has a mischievous mania for charging down on anyone—in good circumstances—who he hears has sent for the doctor, and he excuses himself as being his duty as a christian, quoting scripture authority in his support. The one I have mentioned is a naturally weak and well-intentioned nuisance, and may be said to have a congenital predisposition in his folly. The other is a manufactured plague, and shows us how "The best laid plans of mice and men gang aft agley." With the best intentions in the world, and with the view that the Pacific Islanders or the inhabitants of Borneo shall look upon their pastor as wise in many things, certain missionary manufactories have their neophytes supplied with a few months' instruction by a carpenter and blacksmith, a winter's dissections and lectures in a medical school, and possibly six months in a druggist's shop. Now, if these

same individuals would but do what had been intended, viz., carry their meagre smattering on many subjects amongst the savages whose ignorance they were expected to astonish, they might occupy their niche in the world with suitable profit and credit. But when they desert their fitting place, and are let loose where there are genuine tradesmen, and properly qualified professionals, they become as great a source of mischievous annoyance as even a litigious bush lawyer.

A solitary instance might escape comment, as either a "lusus naturæ," or "monstrum horrendum;" but those I have depicted are specimens of a class which are becoming so frequent as to compel recognition.

I remain, Sir, yours, &c.,

MAORI.

DR. E. M. OWENS AND THE QUEENSLAND MEDICAL BOARD.

To the Editor of *The A.M.G.*

SIR,—I was a candidate for election to the Queensland Club, after having been a resident honorary member for four months. During that time I may safely say that I had not an enemy, and many friends. Three days before the election, one of my proposers came to me and asked me have you been a resident in New South Wales, for a report has got about that you have been, and the Directory shows your name as resident in Sydney; also the same person says you are not registered in Queensland, and the implication left upon some members' minds who have not met you, is that you are an "impostor." Now, I ask the profession, as a body, was not this an underhanded thing to do? Should not this person have come straight to me as a man, and asked me to explain what it meant my name appearing as resident in Sydney, and why I did not register; but no, he would rather that I should be socially degraded by being blackballed; but my true friends, not professional brothers, saved me that disgrace, by withdrawing my name at the last moment. I think it due to the profession to explain how my name appears as resident in Sydney, only I neglected to register. When I left England in 1883, for twelve months travel, I told Churchill's people that I did not know where I should be next year, but perhaps Sydney or Melbourne, and so they put me down instead of "travelling" as resident in Sydney, but there is no street mentioned. When my friend showed me the directory he carefully did not call attention to that fact. Now I did not register in Queensland because I thought that it was a mere matter of form, holding English qualifications, and being registered in England, and I had not got my registration paper with me, though instantly I made up my mind to settle I sent for my papers, and should have registered on their arrival. It may be said that I ought to have gone to the Board and explained all this. I must reply to that that I had not the smallest idea that any importance was attached to registering in Queensland if you were on the English register. In this I was a very "new chum." I now ask the profession, have I sinned so gravely as to only just escape a lifelong disgrace, socially, of being blackballed by the leading club? I may say that I showed privately, to the profession here, letters bearing on my professional stand from Alfred Meadows, Thomas Bryant, Lawson Tait, Anderson, Priestley, Smith, Critchett, &c., also it was known that I bore letters of introduction to Sir Alfred Roberts, Bishop Moorehouse, Dr. Shewen, Dr. West, Dr. Fitzgerald, Dr. Chisholm, and the Hon. Dr. Beaney. I hope some day to present them, but my stopping in Queensland has upset all my plans. They will please excuse

Yours faithfully,

E. MATTHEW OWENS.

Longreach, Brisbane, December, 1884.

MEDICAL APPOINTMENTS.

- Clarke, William Hughes, M.R.C.S.E., to be Public Vaccinator for the Hokitika and Waimoa districts, N.Z.
- Clubbe, Charles Percy Barlee, L.R.C.P., Lond., M.R.C.S.E., elected Honorary Surgeon to the Sydney Children's Hospital, Glebe, N.S.W.
- Eakins, George Reginald, M.D., Brus., L.R.C.P. & R.C.S., Edin., elected Honorary Consulting Physician to the Echuca Hospital, Vic.
- Eddie, Arthur William, M.B. & Ch.M., Aberd., to be Government Medical Officer and Vaccinator for the district of Bombala, N.S.W., vice Dr. W. G. Watson, resigned.
- Hammond, Samuel, L.R.C.P., Edin., M.R.C.S.E., to be Resident Medical Superintendent at the Quarantine Station, North Head, Port Jackson, N.S.W.
- Kirkaldy, William Broad, M.B. & Ch.M., Edin., to be Government Medical Officer at Charleville, Qu., in the room of A. Richardson, M.R.C.S., resigned.
- Lloyd-Apjohn, George Lawrence Marshall, M.B. & Ch.B., Dub., appointed Resident Medical Officer at the Sydney Hospital.
- McCarthy, Charles William, M.D., F.R.C.S.I., M.K.Q.C.P., Irel., appointed Honorary Physician to St. Vincent's Hospital, Sydney.
- MacLachlan, Donald Archibald, L.F.P.S., Glasg., to act as Medical Officer to attend to the destitute poor and aborigines within the district of Orafers, S.A.
- McMurray, Wahab, M.D. & Ch.M., Qu. Univ., Irel., to be Government Medical Officer and Public Vaccinator for the Walgett district, N.S.W., vice Dr. J. S. Wilson, resigned.
- Markham, William, M.D., to be Health Officer at Port Augusta, S.A.
- Morloe, David, M.D., Edin., L.R.C.S., Ed., to be Public Vaccinator for the Auckland district, N.Z.
- Mountain, William John, M.R.C.S.E., to be Public Vaccinator at Bordertown, S.A.
- Muskett, Philip Edward, L.R.C.P. & R.C.S., Edin., elected Honorary Surgeon to the Sydney Hospital.
- Phipps, John Blakemore, M.D., M.R.C.S.E., to be Public Vaccinator at Lancefield and Romsey, Vic., vice Dr. C. Martin, resigned.
- Pincoot, Rupert, M.R.C.S.E., to be Health Officer for port of Geelong, Vic.
- Spellini, Gaspare, M.D., Pavia, appointed Medical Officer to the Palmer River District Hospital, Maytown, Qu.
- Thane, Philip Thornton, L.R.C.P., Lond., M.R.C.S.E., to be Public Vaccinator for the district of Yass, N.S.W.
- Thompson, James, L.R.C.P., Edin., to be Visiting Surgeon to the Wollongong Gaol, N.S.W.
- Thomson, John Rae Menzies, M.B. & Ch.B., Melb., to be Public Vaccinator for the urban, suburban, and rural district of York, W.A.

PUBLICATIONS RECEIVED.

- Hydatid Disease of the Lungs. By J. Davies Thomas, M.D., Lond., F.R.C.S., Eng., Hon. Physician to the Adelaide Hospital, Adelaide: Frearson's, 1884.
- The Medical Chronicle. A Monthly Record of the Progress of the Medical Sciences. Edited by Jas. Niven, M.A., M.B., Cantab., Fellow of Queen's College, Cambridge, and by W. I. Sinclair, M.A., M.D., Aberd., Vol. I., No. 1. (October, 1884.) Manchester: J. E. Cornish.
- Agricultural, Horticultural, and Farm Uses of Carbolic Acid, and its Preparations, compiled by F. C. Calvert and Co., Manchester.
- Abstracts from Papers on Hydatid Disease, Victoria and Tasmania as Health Resorts, the cause of the first Heart Sound, the Leinur system, Antiseptic Treatment and Neuro-Fibromata, By Jas. W. Barrett, M.B., M.R.C.S., Demonstrator of Physiology at King's College. London: Wyman & Sons, 1884.
- Dr. B. W. Richardson's Asclepiad, Vol. I., No. 4. London: Eade and Caulfield.

REPORTED MORTALITY FOR THE MONTH OF OCTOBER, 1884.

Cities and Districts.	†Population.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from							
				Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Child-bearing.
N. S. WALES.											
Sydney	103,379	240	97	...	3	7	3	4	16	25	2
Suburbs	120,832	321	170	...	9	4	7	6	25	22	6
NEW ZEALAND.											
Auckland	27,880	43	17	...	...	3	7	1	1	2	...
Christchurch.....	16,283	11	3	...	...	...	...	...	...	2	...
Dunedin	26,118	37	18	...	...	1	...	1	...	5	...
Wellington	22,626	29	13	...	...	...	4	...	...	3	1
QUEENSLAND.											
Brisbane	26,557	61	44	*	...	...	...	...	...	...	...
Suburbs	9,612	57	28	...	...	...	...	...	...	...	...
SOUTH AUSTRALIA.....	316,637	301	113	3	1	11	...	3	8	25	...
Adelaide	42,605	62	16	...	...	2	...	2	...	10	...
TASMANIA.											
Hobart	28,373	43	23	...	...	1	...	1	...	3	...
Launceston	17,864	28	10	...	...	...	...	...	...	1	1
Hospitals, Asylums, Gaols, &c. .	1,201	29	...	...	...	...	...	...	...	...	...
Country Districts.....	80,920	79	...	...	...	2	3	2	1	...	..
VICTORIA.											
Melbourne	65,791	84	} 243	56	1	9	15	11	6	74	6
Suburbs	238,618	450									

* The Official Monthly Report on the Vital Statistics of Brisbane and Suburbs does not show the number of deaths from the various diseases
† The population of N. S. Wales, Queensland, and Adelaide is that of the census of 1881; New Zealand, South Australia, Tasmania and Victoria show the estimated population at the present date.

METEOROLOGICAL OBSERVATIONS FOR OCTOBER, 1884.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E.....	...	91·8	59·9	41·7	29·907	Inches	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.....	...	68·	56·8	53·	...	2·860	21	70	...	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.....	169·	98·	74·3	45·5	30·005	0·86	8	66	N.E.	...
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.....	...	...	...	...	...	...	...	...	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.....	138·	70·	49·3	34·	...	2·728	17	73	...	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.....	...	78·	53·3	34·	29·786	1·40	13	73	...	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E.....	...	71·	55·	32·	29·843	3·11	12	62	...	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E.....	...	86·	54·5	36·	29·891	3·036	17	...	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ....	...	89·9	63·3	49·3	29·975	2·18	21	61	S.	...
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	140·	66·5	53·	36·5	...	7·331	13	71	...	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

CASE OF SARCOMA OF THE LEFT LUNG, INVOLVING THE DIAPHRAGM AND SPLEEN.

UNDER THE CARE OF A. SHEWEN, M.D., LOND.,
HON. PHYSICIAN PRINCE ALFRED HOSPITAL, SYDNEY.

THE history of this case is somewhat obscure, as the patient was sent out from England last year in consequence of some weakness of the chest. He himself states that he got a chill whilst out shooting some two years ago, which, he says, was followed by an attack of congestion of the lungs. After this he never thoroughly regained his health, and after trying various health resorts, and having resource to various medical men, he was sent out here, by his own account, to avoid the development of phthisis. Be that as it may, he did not suffer any serious inconvenience until he had been some time at sea, when he noticed that one side of his chest was getting larger than the other, and that he was considerably distressed in his breathing.

On landing he consulted Dr. Mackellar, who sent him on to Prince Alfred Hospital, where he was admitted to a private ward on January 2 of this year, 1884.

On examination he was found to be a powerfully-built man, much emaciated, aged 31, a native of Cumberland, unmarried.

When stripped it was at once seen that the left chest was considerably larger than the right, this was particularly apparent in the infra-clavicular region, the superficial veins in that part were also unusually large. The heart was displaced to the right, vocal fremitus was absent below the axillary fold in front, and there was complete absence of resonance in the same region. In the cardiac region there was unusually good

resonance. Respiration disappeared at the axillary fold, but was puerile at left infra-clavicular region, and was bronchial over the abnormally resonant area of cardiac region. Behind, the dullness was almost universal, and very little respiratory murmur could be heard, except immediately against the spinal column. Vocal fremitus was also universally absent.

The patient had no cough. His temperature was normal, and he complained of no very particular pain, although there was a universal querulousness about him which was very distressing.

At this stage of the case we felt considerable difficulty with regard to diagnosis, for there were some points about it, more especially the dilatation of the superficial veins, the peculiar pushing forward, so to speak, of the infra-clavicular region, and the somewhat patchy character of the dullness, which inclined us to believe that we had not a simple case of fluid within the chest. However, in order to settle the matter, I plunged the aspirating needle in on various occasions, at different points, without any result. After which we came to the conclusion that he was suffering from some growth, the nature of which we were not in a position to determine.

To make a long story short, I may say that he remained in the hospital until the 26th of January, and went out in much the same condition as he was on the 2nd.

After this he remained under my care for several weeks, and when I last saw him alive he was much the same as he had been before he went into the hospital. I believe he afterwards consulted a homœopathic practitioner of this city, by whom, I am told, he was most assiduously galvanized, without producing any effect upon the condition of the chest. At all events he died on the 8th of September, 1884. Dr. Skirving was kind enough to make a post-mortem examination in the presence of Dr. Mackellar, Dr. Jenkins, and myself, and the following are his notes of what was found.

"On opening the thorax it was found that the left pleural cavity was entirely occupied with a morbid condition of the left lung, which had displaced the heart to the right, and had much compressed the right lung. This neoplastic formation had led to dense adhesion to the pericardium, to the superior boundaries of the surrounding cavity, and, lastly, to the diaphragm. There were a few adhesive bands between the two layers of the pleura in other situations—another cavity con-

tained a little blood-stained fluid. The growth itself was of a soft, fleshy consistency, on section being of the colour of red granite, involving the entire organ affected, although in varying degree. The neoplasm had, however, entirely displaced the lung tissue in and about the root, and, although careful examination failed to show where the growth primarily began, the general involvement being so great, yet I think, on the whole, we might suspect from the intensity of the process in the above situation, that it arose in the bronchial glands. The tissues of the involved lung throughout were highly friable, and, in many spots, showed the occurrence of considerable hæmorrhages of more or less recent date. Inferiorly the morbid growth had involved the diaphragm and, entering the abdomen, had matted together the tissues immediately contiguous to the point of entrance of the mischief. Among the structures beginning to share in the mischief was the spleen.

There was no abnormality to note in either the other lung or other structures examined.—W.S.S."

Dr. McCormack has been kind enough to prepare some sections of the mass, and the following are the conclusions which he has come to as to the nature of the tumour.

"The growth in question is an example of a small, round-celled sarcoma of the lung, or, adapting Cornil and Ramier's classification, an encephaloid sarcoma, which is identical to the embryo-plastic tumour of the French.

On examining the interior of the tumour with the microscope, I found it composed of a mass of round cells, with no intercellular substance, arranged in parallel rows, with embryonic blood vessels between them, which were filled with broken-down blood, with here and there, in the mass of blood debris, some leucocytes. The cells are larger than a red blood corpuscle, and have no cell wall. The walls of the blood vessels are very thin, and the growth is very vascular, consequently hæmorrhages are very numerous into the substance of the tumour, and sometimes they extend beyond its limit into the alveoli of the lung itself, when it resembles a patch of pneumonia. The cells come into direct contact with the walls of the vessels, and the walls of the vessels being so thin, and rupture so common, one can easily understand how some of these cells might be washed along with the blood current and give rise to a secondary growth, and thus account for the extreme malignancy of this kind of neoplasm.

Besides the natural degeneration and absorption of blood in the numerous hæmorrhages, we find here and there marked traces of mucous degeneration.—A. McC."

DISLOCATION OF THE FIFTH CERVICAL VERTEBRA.—REDUCTION.—RECOVERY.

By GUIDO THON, M.D., HONORARY MEDICAL OFFICER TO THE ROCKHAMPTON HOSPITAL, QUEENSLAND.

On 28th September, 1868, a man named Nichols was brought into the Rockhampton Hospital—then a very small miserable cottage. It was stated that he fell off a dray, and the horse went over him at, I believe, the Crocodile Diggings, about fourteen days before.

Right side paralysed; the muscles of the chest did not act, seemed without motion; no respiratory sound or murmur could be heard; pulse small, and very quick; left arm paralysed, but he could move the hand by itself; head was inclined towards the left side, as was also the uvula; left pupil dilated; incontinence of urine; no headache; could not speak properly, but brought out the sentences in a short jerking way, evidently from being in want of breath, respiration being hurried and somewhat difficult, in fact he could not spare sufficient breath for talking; looked very red about the face and neck, nearly purple-scarlet; sensibility, normal; on the back of the neck was a projection in the region of the sixth cervical vertebra; no crepitus could be felt.

The man was put on the floor. One of us knelt behind him, taking the head between his hands, another steadied the shoulders. I put my hands on and near the prominence at the back of the neck. After a while of steady pulling, gradually increasing, we all could hear, and I could feel, a decided crack, and the prominence disappeared nearly completely. The respiration at once became more regular and easier, and the patient declared he felt much better. On the following day I used a weak electric current, and found both contractibility and sensibility of the muscles normal. There was no apparent improvement of the paralysis.

I did not make any more notes of this case, as I was only called in consultation and to assist. The man, however, recovered completely after several months, and I have often seen him since. He is well. Nothing remains but a slight limp in his right leg.

These meagre notes were made on the spot, but they give only the more prominent symptoms noticed at his arrival at the Hospital. We came to the conclusion that he suffered from a dislocation (partial?) of the fifth cervical vertebra, taking in consideration all symptoms ascertainable, all of which, however, I did not put down.

PECULIAR TREMOR OF HAND AND FOREARM PRODUCED BY PRESSURE ON MEDIAN NERVE AFTER INJURY.

BY A. SHEWEN, M.D., LON., HON. PHYSICIAN TO PRINCE ALFRED HOSPITAL, SYDNEY.

JOHN FRANCIS PATTERSON, married, 7 children, 50, a machine sawyer; been living in Bathurst for eight years; is an old man-o'-wars man; was at sea for 10 or 12 years; during that time had chancres on penis, but there is no history of any secondary eruption.

Up to the time of his accident, 10 months since, he had been very healthy. Whilst at work shifting some timber, a log, weighing 7 or 8 cwt., was allowed by his mates to roll on to his right forearm and lie on the front aspect of the limb for two or three minutes. This happened in the morning, and the arm feeling bruised he did not go to work in the afternoon, but worked next day without any trouble. He worked on for three weeks without any difficulty, when it began to shake suddenly, and he had to leave off work because he was afraid he might get his hand cut off with the circular saw. Since then he has done no work. It is neither better nor worse than it was three weeks after the accident. It does not always show tremulousness, but tremors can be produced at any moment by pressure on the median nerve in any part of its course.

PHORMIUM TENAX (NEW ZEALAND FLAX, AND ITS THERAPEUTIC VALUE.

BY FRANCIS A. MONCKTON, M.R.C.S.E., SURGEON-SUPERINTENDENT, KUMARA HOSPITAL, NEW ZEALAND.

Among the botanical products of New Zealand there is one item for the *Materia Medica* that will prove a valuable auxiliary to the surgeon as soon as its therapeutical effects have become generally known. Somewhere about the year 1869 or 1870 a letter appeared in the *Melbourne Argus*, signed by myself as Provincial Surgeon of Southland, bearing witness to the extraordinary healing properties of the *Phormium Tenax*, commonly known as New Zealand Flax. From that time till the present I have used it in hundreds of cases, including lacerations and amputations of every description, and I have no hesitation in saying that there is nothing known in the old country that can equal it in producing healthy granulations. I use a strong decoction—the stronger the better—made from the roots and the

butts of the leaves, boiled for twelve hours. At one time I had to make it fresh every second day, as it readily ferments and deteriorates, but since carbolic acid came into vogue I keep it for any length of time by adding about an ounce of equal parts of carbolic acid and glycerine to every quart. I require no other antiseptic precautions but simply syringe the lesions occasionally with it and maintain cotton wool or lint, soaked in it, constantly to the parts affected. If there are no foreign matters to be discharged, there will be no discharge, in support of which I will instance the case of an Austrian, named Louis Lourich, whose forearm I lately amputated, after it had been shattered through dynamite. The ligatures were 32 days in coming away, and the amount of pus from the operation up to that time would not altogether amount to a tablespoonful. The same patient had the soft parts of the other forearm torn and blown into such a mass of shreds that the members of the staff thought it was hopelessly beyond repair. I need only say that with the same treatment it became as sound and useful as before, and exhibits only scars, showing where new skin had been formed.

Some time ago a navvy on the Winton Railway works had a loaded truck go over his foot, doubling it on the sole, bursting the integuments and leaving the os calcis nearly bare and the flexor tendons dipping loosely with bits of skin and fascia under the sole of the foot. The man lived in a tent near the works. I instructed one of his mates how to boil down a billy of flax every day, and suspend it with a drip-rag over the injury, and the case recovered perfectly, with no appearance of pus, except on one occasion for 24 hours, through his mates leaving him for some sports or races with an insufficient supply of decoction, which compelled him to use water instead.

In this case no carbolic acid, or anything, was used but the decoction of flax by itself.

I might adduce proofs by scores of its efficacy, but if, owing to these facts being made prominently known through the *Australasian Medical Gazette*, medical men can be induced to test the remedy for themselves, it will require no assertions from me to cause the *Phormium Tenax* to take the premier place as a granulating agent.

I presume that plenty of New Zealand flax can be obtained now in Sydney, but if not, I shall be happy to forward a bag of the dried root for trial in your hospital, or to any other hospital, if their authorities like to pay the freight.

I will add that the New Zealand *Veronica* (a medicine for diarrhoea) that is advertised at home under the name of *Koroniko*, is misspelt, as the Maori name is *Koromiko*, and also that there is a far superior medicine for the same purpose to be

obtained from the New Zealand woodbine, or clematis, known among the South Island natives under the name of *Ti-aka-popohua*, which is a remedy that the old Maoris formerly would always use in preference to veronica, when it could be obtained readily, and especially in the flowering time.

DETACHMENT OF RETINA FOLLOWING SUNSTROKE.

By E. MATTHEWS OWENS, M.R.C.S., L.R.C.P.,
ETC., OF BRISBANE, LATE OF MIDLAND EYE
HOSPITAL, AND BIRMINGHAM HOSPITAL FOR
DISEASES OF WOMEN.

A. H., a lean, wiry man, aged 43, came to consult me on August 25, giving the following account of himself: That he had always been healthy and fairly temperate, never had syphilis, not married, eyesight always been "first rate," (so no myopia) never had so-called "Blight"; in fact, thought his sight was better than most people's; had lived in the bush 15 years.

In January of this year was out with cattle for some hours under powerful sun, which came mostly on his back; he suddenly became unconscious, falling from his horse, was carried to the station and remained insensible for some hours. But when consciousness returned, found that vision in right eye was much impaired, and in left a little dimmed. Right became rapidly worse, so that perception of light was lost. The left did not trouble him much (except that in certain positions he could not see an object clearly), until about a fortnight ago when he felt his sight getting much worse, that he could see people's dress but not their faces, that objects looked crooked. He became very much alarmed and came down to consult me. I found his eyes in following condition:—

Right Eye.—Pupil widely dilated, quite fixed, and insensible to light. Tension + 1. Vitreous was cloudy, but by careful examination with mirror, held at some distance, a greyish opaque body could be made out, bulging forward, but no part of fundus could be seen.

Left Eye.—Vision = $\frac{2}{20}$. Pupil was dilated and decidedly inactive to light. Tension normal. By ophthalmoscope, the upper part of the fundus was bright, but at the lower half of the median a bluish grey waving curtain could be seen thrown into undulations as the eye moved. On close examination, I observed that I had to alter my accommodation to see the vessels on the curtain. The upper part where fundus was bright at the periphery, some small white exudations were to

be made out, and also what at first appeared to be spots of retinal hæmorrhages (apoplectic), but which on more carefully looking I found were little coils of vessels not unlike nævi. This patient's health in other respects was good, though I think his brain power had suffered from the shock of the sunstroke, but there was no loss of any muscular power.

J. D., ætat 47, married, also thin and wiry. This patient presented himself to me on September 3rd, coming from the north, and was also employed in bush work, had always been a very temperate man, never had syphilis. About a month ago, after exposure to the sun for some hours, was "very sick, not unconscious, though muddled in the head," went to bed and had a long heavy sleep, woke up, and felt fairly well in health, but noticed at once that there was something wrong with his eyesight, for when he closed his right eye he could see the dress of people but not their faces, and also when looking in certain directions could see fairly well, but when in another, a veil seem to come before him and the object also; that black spots were floating before his eye. Always had good sight.

On examining his eyes, I found

Right was normal. V. = $\frac{2}{20}$.

Left, V. = $\frac{2}{20}$, but only in one meridian. Field of vision very contracted; pupil rather dilated, and not so active to stimulus of light as the right. By ophthalmoscope, at some little distance, it was easy to see that a detachment of retina had taken place at the upper half of the meridian. Over the detachment could be seen some distorted vessels coursing. The reflection was very marked in this case, doubtless due to the fluid effused between choroid and retina, which being recent was, therefore, perhaps of a straw colour, and of a different consistency to the vitreous, and so the reflection could be easily seen, especially as vitreous was not cloudy. The detachment was not the bluish grey of the former case, but more of a whitish grey; this could be accounted for as the detachment was much more recent, or perhaps colour of fluid behind it had something to do with it.

This being a detachment of upper half of retina, I looked very closely to see if any of the detachment had got into contact again at periphery, for such is likely to happen, as the detachment extends downwards. The peripheral border often heals, but it was not so in this case, the detachment extended from the periphery to the optic nerve and there was no metamorphosis.

REMARKS.—I have been induced to publish these two cases, not because detachment of the retina is uncommon, but because I think we must

look upon the detachment as a result of the sunstroke, for it could not be a coincidence, both cases occurring so immediately after the attack in eyes previously healthy. I have consulted all the authorities I have by me, and can find no mention whatever made of similar cases. I find that by various authors the cause of detachment by retina is given: 1. Spontaneous effusion of blood into vitreous chambers. 2. Myopia and the undue distensions of the coats of the eye. If the detachment occurs in a myope, and only one eye is affected, it is quite easy to learn if detachment is caused by the myopia, by examining the refraction of the sound eye. 3. Pus or lymph in vitreous after choroido-retinitis. The morbid material shrinks with the vitreous and drags the retina away from the choroid. Foreign bodies will cause suppuration of vitreous, and act in the same way. 4. Effusions of blood between sclerotic and choroid. 5. After glaucoma. 6. Concussion and injury with absorption of vitreous; if from injury the further the wound is from the ciliary region the more likely for detachment to ensue. Displacement has been known to occur some years after the injury. 7. Tumours of choroid which causes compression of choroidal vessels, and from these vessels exudes a quantity of fluid between choroid and retina. M. Raehlmann has shown that it is possible to provoke detachment of retina artificially, by injecting a solution of salt into the vitreous. If the vitreous contains at any given moment an excess of salt as compared with that which the blood in choroidal vessels holds in solution, a strong current must set towards the fluid containing the excess of salt, and this fluid must pass through the retina. As the serum of the blood contains a considerable amount of albuminoid substance in solution, the retina would present an obstacle to the passage of fluid through it, so the fluid would accumulate behind the retina, and which would then become detached. Now having briefly looked at most of the causes and if we consider the pathology of detachment of retina, there can be no difficulty in coming to the conclusion that it is a result *likely* to occur after sunstroke. Before going into the pathology, it might be well to glance quite roughly at the anatomy of the retina, consisting as it does of rods, cones, granular layers, and nerve fibres. Between the choroid and retina is a layer of epithelium hexagonal pigment cells, and I think it is with these cells that we have to do. It is a fact that has been shown by Boll, that eyes which have been exposed to the influence of different colours are affected very differently as regards this layer. If eyes have been exposed to red or yellow, or kept in darkness, the pigment layer is quite easily to be separated from the retina ;

but not so if exposed to white, green, or blue, then retina and pigment are so closely connected that they cannot be separated. I believe these experiments were confirmed by Schenke, of Vienna. I think that it is a fair deduction to arrive at, that a great shock may have a somewhat similar effect as colours have, and that the pigment layer may have a good deal to do with the proneness to detachment. I can call to mind one or two cases of detachment that I have seen, where the detachment has taken place after exposing the eyes to a strong glare of a furnace (red or yellow light), the diseases coming on at once without any retinitis or hæmorrhage into vitreous. I dare say that there was general hyperæmia before the detachment occurred in these two cases, but as the patients did not present themselves until detachment had taken place, I cannot be certain. I think we might gather from the foregoing, that the eyes of both patients had been exposed to the sun's glare for some hours; hyperæmia was present, sunstroke came on, the sinuses of the brain being engorged, there was an impediment to the return of blood to the brain from the congested fundus, therefore effusion of serum took place, and the retina was quite ready to be detached because its pigment layer had been exposed to the yellow glare of the dried-up ground. I hope some day to be able to examine a patient directly after sunstroke. I expect I shall find the fundus hyperæmic, and if that is the case, I also think I shall find a retina very prone to detachment. I shall esteem it a great favour if any of my medical brethren will send me notes of any cases bearing upon this disease, for, should I be right, it will be most interesting to some of my brother specialists in England who luckily have no opportunities of studying the above disease as caused by sunstroke. It may be asked what treatment I recommended. I am sorry to say very little, for in all the cases I have seen where pilocarpine, mercury, iodism, puncturing, &c., have been tried, little or no good has resulted. In the case of A. H., I was unwilling to do much for fear of spoiling what little sight he had, and as for J. D., I should like to have punctured, but being new in the colony I dreaded to do so for fear it might be said that I was the cause of his sight being lost. Selfish it might be said, but human nature I reply. If I saw a case at the very beginning I should certainly use pilocarpine injections every morning, keep patient in recumbent posture on his back, bandage the eyes with soft dry compress, no lotions, but rub a little oleate of mercury round the orbit, purge freely, light farinaceous diet and no stimulants, and hope that good might result.

CASE OF FRACTURE OF THE SKULL.

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P. R., æt. 41, a seaman and native of Germany, was admitted into Gladesville Hospital on 24th March, 1883, suffering from melancholia. He had many delusions, among others, imagining that poison was put in his food, and on that account often refusing to take it. He had also constant and distressing hallucinations of hearing.

On Jan. 24, 1884, when in the dormitory, about 9 p.m., he was struck on the left temple with a chamber pot by a fellow patient, who had not before exhibited aggressive tendencies, receiving a depressed fracture of the frontal bone, $2\frac{1}{2}$ inches in length and an inch broad. There was considerable hæmorrhage, and in about an hour coma set in, accompanied by convulsive movements of the right arm and leg, and of the side of the neck, resembling those of epilepsy. The breathing was unaffected, but there was slight strabismus. There was complete retention of urine.

The external wound was enlarged, and the depressed bone removed by operation. No anaesthetic was necessary, as the unconsciousness was complete. The dura mater was exposed but left untouched. The convulsions did not at once cease, but during the night they disappeared and consciousness returned. The patient made an uninterrupted recovery from the immediate effects of the operation, the wound healing well, but leaving a cicatrix depressed nearly half-an-inch, and adherent to the bone.

For nearly three months after the accident he was better mentally than before the injury, seemed to have lost to a great extent his delusions, took interest in his surroundings, and occupied himself in the kitchen and in ward work. He complained at times of pain in the cicatrix, but there were no head symptoms.

At the end of April he had a severe epileptic fit, leaving him unconscious for more than a day, and from this time, on to his death on September 15, he had frequent fits, often in series, and on one occasion was for more than ten hours convulsed. In the intervals between the fits he was quiet, and more or less demented, but he took very little food, became much exhausted, and died eventually with symptoms of serous effusion.

At the post mortem examination it was found that the opening in the skull had, though not closed, diminished greatly in size. On the inner surface several pieces of bone, which had evi-

dently been loosened by the injury, were firmly united, and projected slightly into the cavity of the skull. The unclosed opening had a strong and thick membrane stretched across it, and this was adherent to the dura mater. The dura mater was however intact, and had evidently not been injured at the time of the accident. There was great serous effusion, both in the arachnoid and sub-arachnoid spaces, and in the lateral ventricles. The brain throughout was somewhat wanting in firmness, the gray matter pale and diminished in breadth, but there were no hæmorrhages, or patches of softening and the vessels were not atheromatous.

The skull is of average thickness, and it is difficult to understand how a blow from an ordinary chamber-pot could have caused the severe injury. It will be seen that the opening in the bone corresponds in shape with the curved edge of the pot, and it seems that the bone has given way almost like an egg-shell.

ON THE TREATMENT OF MALIGNANT DISEASE OF THE TONGUE.

READ BEFORE THE N.S.W. BRANCH B.M.A.

BY R. SCOT SKIRVING, M.B., ASSISTANT
PHYSICIAN TO THE PRINCE ALFRED
HOSPITAL, SYDNEY.

THIS evening I propose to bring under your notice the consideration of the treatment of Malignant Disease of the Tongue. I will not detain you with pathological speculations, or clinical points of diagnosis, but adhere simply to that practical portion of the subject which I have referred to.

Specific medical treatment is now on all hands admitted to be valueless. We have still to discover a medicinal agent which will disperse heteroplastic new formations. The common sense plan of endeavouring to maintain the general health in the highest state of efficiency, while at the same time we meet local symptoms, such as fœtor or hæmorrhage by appropriate means, is not to be neglected. The removal of exciting causes of irritation, such as decayed teeth, &c., must also not be forgotten, but beyond this we can do little.

Our resources have therefore to be operative in their character, and these may be divided into A, Palliative; B, Radical. As regards the former division, in a certain class of cases, to which I shall afterwards more particularly refer, this treatment is alone applicable, and in some instances may be strongly indicated. Palliative treatment, at present, practically resolves itself

into two measures, viz., division of the lingual branch of the fifth nerve; or, ligature of one or both lingual arteries.

The Neurotomy, in cases where it is from any cause impossible or inadvisable to attempt radical measures, is a method of treatment which undoubtedly commends itself. Although it is in no sense curative, by its application, we can materially reduce the horrors of the closing scenes of unchecked lingual cancer, of which in former years we were too often the impotent spectators.

Hilton and Moore were the surgeons who first drew the attention of the profession to this procedure. It was carried out with a view of relieving pain, checking the profuse salivation, retarding the progress of the disease, and to allow the surgeon to apply ligatures for the removal of a mass previously deprived of sensibility. Of its value in accomplishing the first two objects I can bear testimony to; as to its retarding the progress of the disease, it has been found to exercise but little effect. As regards the last object for which it was performed, I subsequently hope to show that that consideration may be disregarded should further operative proceedings be deemed advisable. In this little operation the nerve is divided in its course between the border of the internal pterygoid muscle and its entrance into the tongue.

Hilton cut down, saw, and divided the nerve opposite the second molar tooth. Seeing the nerve before its division was an advantage, but the guides to the spot are somewhat uncertain. Moreover, as Erichsen points out, if there be disease of the floor of the mouth it is inapplicable.

Moore, consequently, recommended, and practised, a section further back. He entered the point of a curved bistoury into the mucous membrane of the mouth, three-quarters of an inch behind and below the last molar tooth, and cutting down to the bone he divided the nerve.

Next let us shortly glance at the other palliative treatment by ligature of one or both lingual arteries. This has been practised with a view of retarding the course of the disease, and that by a diminution of vascular supply a retardation may be effected is no doubt true, but unfortunately the benefit is only temporary. The artery has also been tied, to restrain hæmorrhage from an ulcerated lingual surface, when local measures have failed. Lastly, in recent years, especially in private practice, a few surgeons have tied the linguals as a preliminary to more extensive operative procedures, and this, not with any other view than that there should be an absence of bleeding during the operation, and in cases where a case cannot always be under immediate medical super-

vision the operator might feel a degree of confidence that no sudden lethal secondary hæmorrhage would be likely to occur.

This plan has undoubtedly its own merits and fulfils its originators' intentions thoroughly; but, gentlemen, is it often necessary? In the light of our recent improvements in this branch of operative surgery, secondary hæmorrhage, and the dread of bleeding during the operation, are surely diminishing in degree, besides why, if it can be possibly avoided, should we subject the patient to a double operation, slight as the one in question is? In short, if there be no special tendency to bleeding, if the disease be confined to the tongue, and removable by one of the methods which experience has shown to be seldom followed at the time or afterwards by troublesome oozing, if assistants are reliable, and the patient can be retained under immediate observation, it seems to me that the operation is unnecessary. In opposite conditions it deserves a trial and will doubtless win for itself a place in the recognised resources at our disposal.

The chief embarrassments to this operating are the chance of an abnormality in position of the artery (by no means an unfrequent occurrence), the fact that you are "working in a hole," and the importance of the contiguous structures.

Several different plans of operating are taught. 1st. To trust to the greater cornu of the hyoid bone as a guide; 2ndly. To tie outside the posterior belly of the digastric muscle (French); 3rdly. To tie in the digastric triangle, using for the deep dissection the boundaries of that space as a guide.

I am persuaded that of these methods the last is by far the best. Against the first method I would point out that the relation of the vessel to the greater cornu of the hyoid bone is uncertain, while as regards the second method I would remark that it involves a more extensive dissection than is desirable, and that, moreover, you reach the first part of the lingual artery, which is most subject to be placed in abnormal relations to contiguous parts. I have repeatedly tied the vessel on the dead subject in all three ways, and have no hesitation in saying that the method I am shortly about to describe is the best. The abnormality to which the lingual artery is most subject is that, instead of taking its origin from the external carotid, it occasionally comes from the facial behind the sub-maxillary gland and then passes through the mylo-hyoid muscle to reach the tongue.

I have tied this blood-vessel once on the living body. This was in the case of an officer of one of Her Majesty's ships on this station, a patient in the Prince Alfred Hospital, under the care of

Dr. Goode, during my term of office as Medical Superintendent. Dr. Goode had, in the instance referred to, successfully removed the anterior two-thirds of the patient's tongue for malignant disease, by means of ecraseurs, the wires of which had been passed through a submental opening. All went well till about the eighth day, when secondary hæmorrhage set in, which recurred on several subsequent occasions; the right lingual was seen jetting in the sloughy stump, but could not be secured owing to the friable state of the tissues. Transfixion of the tissues around with a wire, which was then twisted tight, was practised on two occasions with success, but on the night of the thirteenth day smart bleeding recommenced, and as the patient was somewhat exhausted, I deemed it inadvisable to temporize any longer. I, therefore, with Dr. Jenkins' assistance, had him placed under chloroform and operated in the following manner:—A curved incision was made from the symphysis menti to near the angle of the jaw, the most dependent part of which reached to a couple of lines below the level of the hyoid bone. This now exposed the lower edge of the submaxillary gland, which, with the skin flap, was dissected up. This left a triangle, the sides being formed by the two bellies of the digastric muscle, the base, of course, being superior; in this space, lying on the floor formed by the hyo-glossus, was the ninth nerve and the lingual vein; the former I hooked up out of the way, the latter I tied in two places and divided. Pulsation of the vessel I was in search of could be plainly felt beneath the fibres of the hyo-glossus; these I scraped through, and passing the aneurism needle, secured the artery without further trouble. No subsequent hæmorrhage followed in this case, and the patient is now in England, as yet free from a recurrence of the disease.

Having thus briefly referred to the Palliative operative measures, and the cases in which they are suitable, I would next pass on to review the various methods of Radical treatment—to contrast their relative advantages and disadvantages, and lastly, to tell you the conclusions I have arrived at from observation and study of such cases and operations. In a paper such as this, it would be impossible and profitless to go into all the numberless modifications of methods which have from time to time been introduced into practice for the removal of part or whole of the tongue. I shall not, therefore, weary you by attempting to do this, but shall confine myself almost entirely to the consideration of types of methods for the removal of the entire organ. Of the various means by which we may effect this object I would mention the knife, the ligature, the scissors, the

thermo-cautery, and the simple or galvano-caustic ecraseurs.

With reference to excision by the knife simply, we may at once dismiss it, by saying that, though useful in removing anterior portions of the tongue, and in the concluding stages of Syme's method, it is not to be advised in total extirpations, profuse and alarming hæmorrhage often occurring. As regards the use of the ligature, the practical difficulty of keeping it sufficiently tight to ensure continuous strangulation of the part to be removed, as well as the suffering even after division of the lingual nerve, and fœtor caused by the necrosing mass of tissue, are sufficient reasons for allowing it to fall into a deserved disuse.

In operations for removal of the tongue, surgeons, in order to gain room, have been in the habit of taking certain steps, whereby they might have increased space to work in, and to enable them with more certainty to cope with the hæmorrhage incident to the operation. For this purpose the cheek (avoiding the parotid duct) has by Fourneau, Jordan, and Collis been incised; by some the jaw has been split, while others again have attained the same end by more or less extensive submental openings. It has now been shown that splitting the cheek, although it does not materially increase the gravity of the operation, is, in the large majority of cases, unnecessary, and leaves a disfigurement which can profitably be dispensed with. By none has this been more conclusively proved than by Mr. Walter Whitehead, of Manchester, in his intra-buccal method of excision by scissors, which shortly is described it as follows:—

1. The mouth is fully opened by a gag.
2. A double ligature being passed through the tongue, an inch from the tip, it is drawn outwards and upwards.
3. After the manner of Paget, the attachments of the tongue to the jaw and pillars of the fauces are divided with straight scissors.
4. The muscles attached to the base of the tongue are next cut across by a series of short successive snips, until the entire tongue is separated on the plane of the inferior border of the lower jaw and as far back as the safety of the epiglottis will admit of.
5. The lingual or other arteries are twisted as divided. Mr. Whitehead finds pressure with a piece of sponge for a minute sufficient to check the hæmorrhage temporarily, and sometimes permanently.
6. A single loop of silk is passed by a long needle through the remains of the glosso-epiglottidean fold of mucous membrane, as a means of drawing forwards the floor of the mouth in cases of subsequent hæmorrhage.

Such, then, shortly considered, is Mr. Whitehead's operation. For it, he contends, that certain advantages are gained.

That there is no necessity to enlarge the cavity of the mouth, and the steps of the operation are simple and rapidly performed; that the bugbear of surgeons, viz, hæmorrhage, is more imaginary than real, as shown by his experience; that secondary hæmorrhage, septicæmia, and subsequent respiratory and deglutitionary troubles are reduced to a minimum.

In support of these views he brings forward the record of 32 cases. Of these only one died directly from the operation, viz., from shock. The other fatal cases were as follows: two died from causes remote from the operation; one from the effects apparently of a tracheotomy, which had been deemed a necessary prelude to the major operation—(it was a case of macro-glossia); another case operated on by Mr. Jolly died 21 days after operation, cause of death not being stated. The last of the fatal cases fell a victim to septic pneumonia, but it is only just to add that in this patient, not only the tongue but the floor of the mouth and the sub-maxillary glands had been removed, the two latter structures through a sub-maxillary incision.

Including this case, however, in his general results, a mortality of only about 21 per cent. is indicated. This, as Mr. Whitehead points out, is an advance on the results shown by all previous methods, which have been variously put down at from about 30 to 60 per cent. of deaths. Too much reliance, however, on these apparently favourable results ought not to be put, I think, as firstly, an insufficient number are recorded on the one side, and, on the other hand, we have no thoroughly reliable statistical information to guide us in fixing a mortality; lastly, both results are open to the common objection that success in surgery in a particular operation does not altogether depend on the operation, but to a great extent on the cause for which that operation was undertaken.

Billroth had, it appears, coincident with Mr. Whitehead's practice, been in the habit of using an almost identical method, with this difference, that he tied the lingual arteries before removing the tongue. This is a minor difference, and in cases where more than the tongue is affected, such as a slight involvement of the sides of the floor of the mouth, or where the sub-maxillary glands require removal, doubtless his plan is a good one, more especially as the incisions so made can be well utilised for drainage purposes. Billroth, in his practice, has had a success of 84·4 per cent., and has even, after severe operations, such as those just referred to, never

experienced cellulitis, diphtheria, or bronchial pneumonia.

A modification of Mr. Whitehead's plan I have, on two occasions, seen practised by my colleague, Dr. Fortescue. He puts two ligatures through the respective sides of the tongue, then incises the organ deeply from the glosso-epiglottidean mucous reflexion forwards in the median line, a procedure, not, as is well known from anatomical reasons, likely to be followed by much bleeding, next cutting the mucous membrane on each side, as described in Whitehead's method, he clears the lateral and deep attachments with his fingers, and then snips everything away except a little tuft of tissue in which the vessel of each respective side is included; this is tied and the half tongue removed. A similar procedure removes the remaining half. Should the lingual be cut and spout, it is seized with a long special pair of Pean's forceps and secured on the spot. This modification seems to me to give you more time, and allows you to take precautions against hæmorrhage more effectually than the original plan of Whitehead.

Although it has truly been shown that the fear of hæmorrhage is too prominent in many minds, still the possibility of it occurring must not be lost sight of. Without reliable assistants, it is an extremely unpleasant time when the lingual arteries are playing across one another in the dark cavity of the throat. And at this point I would like to refer to the fact that although the patient being in a sitting posture makes it somewhat easier for the operator, it increases the risks to the patient of syncope during the operation, or of blood finding its way into and coagulating in the respiratory tract.

I next pass on to briefly mention the operation of Sedillot and Syme, in which to gain room to work in and to completely remove the disease the jaw was divided in the middle line. I will not refer to the steps of this operation beyond saying that the tongue being transfixed with a stout ligature and drawn forwards, the jaw is divided and the tongue cleared and removed by knife, scissors, or more recently by simple or galvanic *ectraseurs*, the linguals being tied either before cutting them, if they are seen, or subsequently, when they jet on section. Drainage is practised through the lower end of the external incision.

Mr. Syme contended that to entirely remove an extensively diseased tongue splitting the jaw was a necessary procedure, and so at that time it undoubtedly was. The main points in favour of this operation are the room to work in gained and the greater certainty of removing all the diseased tissues. Against it, is the undoubted

added gravity of the operation, due to the splitting of the jaw, the length of time taken in its performance, and the complicated steps entailed such as the section and drilling of the inferior maxilla. The mortality in this operation is put down at between 50 and 60 per cent. Another disadvantage which I might mention is the necessity of removing the two front teeth when the V shaped section of the maxilla, as recommended by Sedillot, is practised. This, of course, is not necessarily required when the mesial section of Syme is used.

Professor Spence used to say that there was less danger in this method of respiratory difficulty supervening, as the genio-hyoid muscles were left intact, the genio-hyo-glossi being alone separated. And here I would like to mention that I have noticed—and somewhere in the writings of Mr. Heath a similar observation is made—that it is not so much in total excisions of the tongue that there are respiratory difficulties from loss of the anterior supports of the epiglottis, but rather in partial excisions, where a weight remaining, but which, being but little supported, tends to fall back, and so through the epiglottis to narrow the respiratory tract.

Turning now to submental plans of operating, I would allude to that of Regnoli, of Pisa. This surgeon made a semi-lunar incision along the line of the lower jaw, and bisected this with a mesial cut down to the level of the hyoid bone, the triangular flaps so marked out were now dissected back and the muscles and mylo-hyoid space exposed. The anterior bellies of the digastrics, genio-hyoids, genio-hyo-glossi, with the mylo-hyoids were divided and the cavity of the mouth opened into. The tongue was next drawn out through the submental aperture and removed by knife, scissors, or ecraseur. In cases where the tongue alone is involved this operation seems to me an unnecessarily "large order," and has no special advantage sufficient to make it be preferred to intra-buccal methods. In cases where the disease is very extensive the method by dividing the jaw allows you to cope with the wide area of mischief better, and as regards ease in dealing with bleeding this latter method has also the advantage; finally, the submental drainage opening is common to both methods. The amount of disfigurement is, if anything, less in Syme's operation, and the risk of wounding the facial arteries in the semi-lunar incision, which has occurred in Regnoli's operation, is not incurred in Syme's.

The mortality in the Italian method is said to be over 25 per cent.

(To be continued in next issue.)

ASSOCIATION INTELLIGENCE.

VICTORIAN BRANCH.

ORDINARY MONTHLY MEETING.

MELBOURNE, WEDNESDAY, DECEMBER 17, 1884.

Hall of the Royal Society.

The President, Mr. Rudall, in the chair.

NEW MEMBERS.

The Hon. Secretary announced the election of Dr. Herdegen, of Nhill, and Dr. Spellini, of Maytown.

A CORRECTION.

The President desired that a correction should be made in the report of his remarks made at the previous meeting on the case of injury to the cervical spine, related by Dr. Lucas. He (the President) mentioned a case reported by Mr. Simon, what he aptly termed "lateral fracture of the spine." A girl fell down an embankment, and walked three miles afterwards, and for eleven days continued at her occupation. On the 15th day she applied for admission at St. Thomas's Hospital, on account of severe pain in her neck. There was no irregularity of the spine; no paralysis nor anaesthesia. The next day she had numbness and twitching of the limbs, with more or less loss of voluntary motion and sensation. She died with high fever on the 18th day after the accident. On post mortem examination there was found a horizontal fracture of the seventh cervical vertebra without any displacement and without any tearing of the posterior common ligament. The vertebral canal contained between its osseous walls and the dura mater a large quantity of pus which, from two inches below the foramen magnum, descended the whole length of the cord. There was no softening nor other change in the cord itself, as proved by microscopical examination, and no other disease in the body.

The following paper was then read by the author:—

ON THE INJURIOUS EFFECTS OF CLOSE CONFINEMENT AND OVERWORK.

By WILLIAM HENRY CUTTS, M.D., ETC.

I SHALL consider these principally as they show themselves in women, because they are worse in the way of these injurious effects than the other sex, and from their weaker physique are less able to bear them.

In this colony we are all workers in some line or other, and most of us work long hours, or under high pressure, or both. The Bishop tells us that he works sixteen hours a day, and finds himself none the worse for it. But the Bishop is a strong man, and is master of his work. He is enthusiastic and his heart is in it. Then it is various, a happy combination of the mental and moral, and it takes him a good deal into the open air. Still, between him and our eight hours tradesmen the interval is wide, and in this respect they are better off than any other class in the community. But if they are to give an equivalent for their wages they need to make the most of

their time ; and, no doubt, eight hours of honest work, especially in the heavier trades and in summer, is enough for any man.

But, unfortunately, those who most need this shortening of their hours of labour don't get it, our shop hands for example, boys and girls, men and women, who are at work from early to late, and under conditions most unfavourable to health.

Perhaps this class, especially the female part of it, affords the best illustration of what I mean by close confinement and overwork and the evils arising from their combination. Their working day is from ten to twelve and fourteen hours. During this time they are standing serving their customers, or measuring some half-dozen paces to and fro behind the counter, just motion enough to weary and cramp their limbs, and hardly room enough to relieve them with a good stretch, the only break being a few minutes in the middle of the day, in which to swallow their dinner. Probably the shop is close and stuffy from defective ventilation and the crowding of goods, and these often give out a fine dust that is irritating to the air passages, and this irritation may end in chronic cough and consumption. Very likely the drainage is also defective, and the atmosphere of the shop is made further unwholesome by the fumes that rise from the damp and nasty foundations ; and is certain to be fouled by the number of lungs breathing it, by gas and the products of gas consumption. Then the work, though not in itself laborious, comes to be so in effect, from its character, duration, and surroundings. There is a constant strain on particular muscles and on particular actions of the same muscles, which from its sameness, its continuousness, and not being relieved or compensated by more general muscular action, is exhausting out of all proportion to its mechanical amount. There is no healthy stimulation of the heart's action, driving the blood merrily through the arteries and back through the veins ; no increased activity of respiration taking in more oxygen and giving out more carbonic acid, but a shallow catchy breathing of an atmosphere getting more vitiated as the hours wear on, and a sluggish or feeble and rapid pulse, and a general oppression and depression of all the functions and processes of life.

Now, here we have a concurrence of conditions that includes well nigh every element of physical exhaustion, and it may well be that the effects are bad at the time and still worse afterwards. The particular symptoms induced will vary somewhat according to age and natural constitution, but some of the following are sure to be present : headache, neuralgic and muscular pains, especially of the back and side, palpitation of the heart,

præcordial oppression, indigestion, loss of appetite, constipation, anæmia, leucorrhœa, varicose veins, &c., &c. These and many more, as I well know from hospital out-door practice, are the common lot of this unfortunate class. And when the day's work is over, it is too late to take a walk or other out-door recreation, or they are too fagged to have the heart for it, and all they are fit for is to go to bed or to some place of amusement, where a little fitful and not always wholesome excitement serves at least to save mind and body from utter stagnation.

But have they not their Sundays to themselves to spend as they please ? Well, it must be a grievous lot that has not some mitigating circumstance ; and, fortunately, it is open to some of them, but by no means to all, to have an outing on Sundays and holidays into the country, or to the seaside. But this, though better than nothing, does not do the good that might be supposed. I have frequently observed that women who are confined in house or shop all the week are oppressed and not stimulated by country and especially by sea air ; it is too strong for them, they tell you, gives them headache, makes them tired and sleepy, and they return home more weary than if they had been at work all day. Of course, the remedy for this is not to stop at home, but to get out oftener and more regularly. The fault lies in the unnatural life led during the rest of the week, and nothing shows more forcibly the low state of vitality to which they are reduced than the fact that the fresh air of the country thus acts, for the time, not as a tonic, but as a drug.

Now what is to be done for these girls and women ? Of course, when they come to us as patients, we treat them as such ; and, no doubt, judicious treatment is often beneficial, as a course of purgatives and tonics, iron and aloes, or quinine and nitro-muriatic acid, with small doses of sulphate of magnesia.

Still, this prescribing for those who have to return to the self-same conditions that have caused their ailments, and are certain to cause them again, is a poor business after all ; and when everything has been done that comes under the head of medical treatment, something more important remains behind, that is, the removal of the offending conditions by sanitary measures and the shortening of the hours of labour ; and it seems likely from past experience, that the only way of effecting the latter is by legislation.

This admitted, the question arises, what form is legislation to take ? Three proposals have been made. 1.—That shops shall be kept open for a limited number of hours only per day, these to be arranged according to the convenience of the

trade or the individual, so long as this limit is not exceeded. 2.—That all shops shall close at a certain hour, say 7 p.m. This is the recommendation of the shops commission. 3.—That the hours of the *employés* be limited; the hours of the *shops* to be left as at present without State interference. Of these proposals, the first would be inconvenient in the working, I should think, if not impracticable. The second is simple and effective, like most other heroic remedies; but it would bear hard on particular trades and on particular tradesmen, among the worthiest of their class, those who work their shops with their own labour and that of their families. The third proposal seems free from objection. It is not new. In principle and almost in form it is already embodied in English statute law, and in our own. Then it has the rare merit that it just meets the case and no more. It involves the least possible state interference with private action compatible with the attainment of its object, and leaves the employer at full liberty to make his own arrangements.

So far, I have spoken chiefly of our shop women; but much that I have said applies to our factory hands, needle-women and machine sewers. The latter is one of the most trying employments a woman can take to. It necessitates the same sitting and stooping posture all through, and the same continuous strain on particular muscles. And when the hours are long, as is usually the case when the work is done at home, or the surroundings are unwholesome, as in close and steaming workshops, this kind of labour reaches its maximum of injurious effect.

This is a fitting place to make a few general remarks bearing on my subject. One is, that our young women have not the physical strength and endurance their mothers had at the same age, who were born and brought up under harder conditions of climate, &c. In illustration of this, I might cite my own experience, and I believe it is general, that our young mothers cannot nurse their children as their mothers did before them, and have often to give up the attempt whilst still in the prime of life.

Another remark pertinent to my subject is, that our climate is more exhausting than that of the old country. This fact, in part, concurs with and explains the former; but it deserves separate consideration on its own account, and is an important factor in deciding what are the most suitable employments for our young people, and the conditions under which they should be carried on; and, taken together, they emphasise what I have said as to the injurious effects of close confinement and overwork. Looking at the matter from this point of view, one cannot but regard it

as a national misfortune that so many of our young women take to employments that are unsuited alike to the climate and to their physique, that introduce the seeds of disease into the constitution at the very time when it ought to be developing to its best, that are productive of many social and domestic evils, and that, to say the least, are a poor preparation for the duties and responsibilities of after life. But this comes of interfering with the laws of nature, and is another instance of the far reaching complications and disturbances that arise when men in their impiety and shortsightedness set up to teach their Creator how to manage his own world.

I may mention here that I have observed that our young women easily take on tubercular bronchitis, and that its course is unusually rapid. Only the other day two cases of death from this disease, after a very short illness, came under my notice. Both girls were supposed to have been previously quite healthy, and there was no history of phthisis in either. One of them was a factory hand, and the other plied her needle at home. Had they been in domestic service, they would probably have been living now.

It is likely, I think, that many of the cases of consumption that occur among our young people, and that are adduced as proof that we are as subject to this scourge in Victoria as they are in Europe, are to be put down rather to the unsuitableness of their occupations than to the unfriendliness of the climate.

Considerations of this kind have an important bearing on the future of the colony, for if our girls grow up sapless and weedy young women, what will their children be, and their children's children?

But to come back to the immediate subject of my paper. Shop hands and needle-women are not the only sufferers from close confinement and overwork. I have said that our working men are well off in these respects, but many of their wives are not; and, speaking generally, the poor man, as he is called, is much better off in this colony than the poor man's wife. If she has a large family, as most poor women have, she has a hard time of it. Her day is a constant round of cooking, scrubbing, making, mending, &c., with a child in arms, or one in prospect, from the time she gets up to the time she goes to bed, broken only by an occasional visit to the grocer's and butcher's across the street, and possibly to the "pub" at the next corner. She probably does as much actual work, spends as much nervous and muscular force as her husband, and her hours are nearly twice as long, to say nothing of pregnancy, lying-in and nursing. She has no leisure, but is always doing, and has never done; no interval

of rest but such as appetite and sleep forcibly impose. And she cannot strike as her husband does when he thinks himself wronged, and when he is on strike, the loss and hardship are mostly hers. Even Sunday brings her little relief, for she is her own servant, and has still to order her house and attend to her family. And holidays are not to her what they are to everybody else. If she gets an outing into the country, she cannot leave her work and anxieties behind, for she has to take her children with her, and they have as many wants and need more looking after than when at home. And so, after a day's laborious pleasure, she is glad to get home again, knocked up rather than refreshed by the change, and with her temper none the sweeter, perhaps, for the little mishaps of the day. If she has grown-up daughters that might help her, they are out at service, or more likely, in the factory, and want their leisure to themselves, or they are too genteel for domestic employments, and are preparing for matriculation or qualifying for State school teachers. Her husband can help in many ways, if so minded, for he has ample leisure, and many husbands do; but most men are awkward at housework, and some are churlish, and would rather spend their evenings outside; and in the whole, I am bound to say that in my experience the poor wife does not get the help from her husband she has a right to expect, but has to take much more than her fair share of the work and burden of life.

Of course, all poor wives are not so badly off as I have described, but to my knowledge a good many of them are; and this should be taken into account when unfavourable comment is made on the habits of some of them. There is infinitely more excuse for them than for their self-indulgent husbands.

It is some mitigation of their hard lot that they generally enjoy fair health. They are subject to the local ailments that arise from frequent pregnancy, and from getting about too soon after confinement, and these are aggravated by being on their feet all day; but the hard, active life they lead ensures free respiration of such air as they live in, good appetite and sound sleep, and these support the bodily strain and lessen the ill effects of their, often, bad physical surroundings.

But this remark must be guarded against being misunderstood. Many women who can well afford to keep a servant have the idea that they take sufficient exercise when they do their own house work, and need no other. This is a mistake. Exercise means something more than merely going through a certain amount of increased muscular activity, no matter in what surroundings, and irrespective of its effect on the general system.

It means also, increased activity of respiration, by which the former is supported and sustained. To this, two conditions are necessary—free chest expansion and a plentiful supply of pure air; the latter furnishes the needful oxygen, and the former ensures its absorption; and the amount of the one determines the amount of the other. Hence, exercise should be active enough to fully expand the lungs, and should be taken in a free and pure atmosphere; and these conditions are obviously best fulfilled in some form of out-door activity, whether as work or pleasure, that engages the whole muscular system. It follows that it is not enough indolently to breathe the comparatively pure air even of large and well ventilated rooms. On the other hand, indoor and sedentary employments are a poor substitute for exercise in the open air, as in these the muscular action is limited and partial, does little to open the lungs, and is therefore unsupported by increased oxygenation of the blood. According to its conditions, then, work may be sheer exhausting labour, or it may become an invigorating and even pleasurable exercise.

The importance of the respiratory function can hardly be overstated, as on this depends the due oxygenation of the blood and the activity of all the vital processes. It is the oxygen we take in in respiration that burns up the body waste, and the imperfectly formed, disease-carrying products of faulty assimilation, to be eliminated, washed out of the system, so to speak, as carbonic acid, urea, &c. Now most of the diseases that women suffer from are caused by defective elimination in some form or other. The blood becomes poisoned with its own refuse, just as our streets do when not periodically flushed, and circulating through every part of the body, carries the poison to every part, depresses the heart's action, starves the muscles, overworks and then blocks up the emunctories, arrests secretion, loads the bowels, above all, irritates or paralyzes the nervous centres, and thus either dries up vital action at its sources, or irritates it into all manner of diseased activities and manifestations. The most familiar instance of this defective elimination is to be found in constipation, of which I need only say that its commonness in women as compared with men, shows its connection with a sedentary life; and that it is associated either as cause or effect, or both, with almost all their special ailments.

But there are many others, besides those I have mentioned, who are confined in doors more than is good for them, from necessity or ignorance, or mere habit; and it is remarkable how easily this habit is acquired, and how strong it grows. But usage, which sanctions so many bad things,

is most at fault here. It is thought quite the thing for my lady to drive out in her carriage, but it is only a strong minded woman who dare take a constitutional on foot, yet nature asserts herself in spite of social orthodoxies, and levels up from the lower to the higher. A smart walk on the St. Kilda or Brighton beach, or a daily airing in one of our parks or gardens, places all grades on the same footing in this respect, or if there is a difference, it is in favour of nature's own locomotion. Driving out in an easy carriage is not exercise, and my lady is absorbing little more oxygen when dashing along behind her favourite pair than when lolling on her couch reading the latest yellow-back.

But I have a special word to say in conclusion, on behalf of the poor gentlewoman, whose lot is hard in this colony before marriage, and sometimes harder still after it. Of gentle birth, instincts and manners, tenderly brought up, unaccustomed to rough work and physically unfit for it, she comes out here to find herself at a discount, and escapes some mechanical or educational drudgery by marrying a gentleman as poor as herself. Well, love in a cottage and £200 a year will do a good deal at the start with judicious management. What keeps one will keep two ; but when three or four children come to be added to the establishment and have to be provided for and educated as becomes young gentlefolk, and this with but little increment of salary, earned or unearned, then the pressure comes to be felt, and the wife, who takes an honest pride in her family and home, has all she can do to make ends meet. She has to make many sacrifices, give up many little *agrément*s, do much that would be left to rougher hands, and encroach more and more on the hours that should be given to rest and relaxation, in order to keep pace with the ever increasing requirements of her household.

It is to be feared there are many gentlewomen in this colony who are more or less in this case, though we hear little about them, as they are too proud and patient to complain. To them and to all others who, whether from necessity or not, spend all or nearly all their day in doors my paper applies. It cannot be too strongly insisted on that indoor occupations are less healthy than those that are followed wholly or in part in the open air. The same amount of bodily exertion produces more exhaustion, especially of the nervous system. Women, therefore, whose business or domestic duties confine them much in the house are at a great disadvantage in this matter relatively to the other sex ; and this natural disadvantage is increased by their weaker nerves and more languid capillary circulation. No wonder, then, that they suffer from such a variety and

complication of bodily ills, objective and subjective, that Cullen's nosology has become out of date, and we have to invent new names for the new diseases of our modern civilization.

Men, of necessity, are much in the open air ; they have to go to business, to go about in connection with their business, to go home in the evening, &c. ; then they fish, or shoot, or play bowls, or go to the races, or potter about the garden ; and if the occasion does not otherwise arise they make it.

But the poor wife, well, home is her proper place, the sphere assigned her by Providence for illustrating the virtues and duties of domestic life, &c. ; and so it happens from various causes, mostly creditable on the wife's side, not always unselfish on the husband's, that she comes to be a house drudge and little else. She bears his children, presides over his house, puts up with his humours, prepares his dainty dishes, and gets up his immaculate linen, &c., for all which she has her board and lodging free and the proud satisfaction of having a lord and master all to herself. What more can any reasonable woman require ?

But I would not be too hard on the men ; many of them simply don't think about the matter. It does not occur to them that their wives are human beings like themselves, and have precisely the same bodily needs.

" Evil is wrought by want of thought,
As well as want of heart."

Others have had quite enough of it by the time the day's work is over, are glad to get home for rest and quiet, and, once there, are not disposed to turn out with their wives or without them. Paterfamilias has his own share of troubles, and may be excused if not always in a mood for domestic heroics. But let all husbands bethink them that the well-being of the home depends largely on the bodily health of the wife and mother, that when this is at fault there is likely to be some hitch in domestic arrangements, some want of smoothness in domestic relations. The angelic side of a woman's nature is hardly likely to come out when the liver is sluggish, or the nerves unstrung. It is worth the husband's while, then, to see to his wife's health, even though if something of personal convenience, or luxury, or of house nattyneess should have to be given up. For this end he should treat her as he treats himself ; should associate her with his pleasures and relaxations as far as possible, and, where this cannot be, should at least see that all reasonable opportunities of this kind are afforded her, and, if need be, insist on their being made use of.

But though the one injurious effect of close confinement and overwork that was most in my

thoughts when I began to write, I have but hinted at. It is this. I am convinced, from a long professional experience in this colony, that not a little of the alcoholic intemperance that is too common among our women is to be put down to the causes and conditions I have been attempting to describe. Need it surprise us if, cooped up in shops, or shut in at home from the pure air, the sunlight, the pleasant sights and sounds, and all the joyous life of the outer world, with little to vary or brighten their existence, or quicken its dull routine into cheerful activity, tried in temper, faded in mind, exhausted in body, without energy, without heart, subject to all manner of perverted sensibilities and cravings, and, withal, unable to eat, they should seek a brief respite from suffering in the easy, agreeable, but delusive relief of stimulants? And why not? Are not stimulants necessary in these cases? Perhaps they are, but if so, assuredly they are a necessary evil. Taken under these circumstances, they only tide over the present need, and this at an ever increasing loss. They but draw on the strength of to-morrow, and when to-morrow comes the obligation has to be renewed with interest, and this goes on day after day, interest and compound interest all the while accumulating, till these renewals can be no longer met and then, bankruptcy. I do not deny that stimulants have their legitimate use, though, in the case of women, for reasons special to them, that use should be closely watched and strictly guarded. But I say emphatically that, when a low condition of bodily health has been induced by the causes I have been describing, nothing short of their removal can effect any real improvement, and that the attempt to keep the machine going by artificially increasing the pressure, whilst the conditions of its healthy working are still absent, can only end in its breaking down all the sooner, and the more hopelessly. This is a delicate subject, and I am loth to lessen the effect of my warning by any seeming exaggeration. But it is my deliberate conviction that the woman who has contracted the habit of taking stimulants under the circumstances I have indicated, especially who take them to relieve *those fits of nervous depression* that are so common a result of close confinement, is dangerously near, if not already on the road that leads to certain ruin.

The matter of this paper, perhaps, contains nothing you do not already know as well as I, and its only merit, if it has any, is that it puts plain truths in a plain way. For the manner, as I have affected neither scientific precision nor scientific language, the subject is important and deserves to be more generally understood. I have, therefore, purposely adopted a popular style that the people may understand me.

In the discussion which followed, the PRESIDENT thought that perhaps the excessive use of stimulants by women in this colony was not greater than that possibly prevailing in the neighbouring colonies. On this point, however, he did not speak with confidence. With reference to the injurious effects of the sewing machine, there was not only the absolute fatigue therefrom resulting, but the mischief arising from the continual enervation of the central organ to direct those muscles during many hours.

Dr. GRAHAM hoped that so practical a paper would enjoy a publicity beyond that which its appearance in a medical journal only would procure for it. He was quite sure that the excessive indulgence in stimulants among women was on the increase.

Dr. HENRY believed also that the habitual use of stimulants among women was increasing, although the effect might not be shown in actual intoxication. He thought, however, that the immoderate drinking of tea was not less harmful than that of alcoholic liquida. The frequency of leucorrhoea, he thought, often promoted a desire for stimulants.

Dr. SIMMONS was satisfied that much of the exhaustion to which Dr. Cutts had referred was caused by the close confinement of many young women in ill-ventilated workrooms. He regarded it as an almost religious duty on the part of the Government to give its attention to this evil with a view to its removal.

Dr. CUTTS, in reply, said he had not raised the question of whether women drank more than men. He was, however, sure that they drank in excess of what was good for them. The evil of tea-drinking was, however, exaggerated. It was, however, no doubt injurious to make the tea so as to include in the infusion the bitter and astringent principle. The large quantity of sugar taken with it was also a serious fault, as it impaired digestion. He repeated that alcoholism was certainly on the increase among women in this country, and as there was not the excuse of pinching poverty to palliate it, as there was in England, it was the more emphatically to be condemned.

The next paper read was entitled "Some Notes on Electro-motor Force," by Louis Henry, M.D., etc., which will be published in our next issue.

SOUTH AUSTRALIAN BRANCH.

THE usual monthly meeting was held at the Adelaide Hospital on November 27th, 1884. The President (Dr. C. Gosse) in the chair.

EXHIBITS.—Dr. Gardner exhibited the patient upon whom he had operated for the removal of the mass of lymphadenomata upon each side of the neck, extending from the ramus of the jaw to the clavicles, pointing out the successful preservation of the external jugular vein by means of a central flap.

Also three cases of radical cure of inguinal hernia, by means of gold-wire, according to Mr. Fitzgerald's plan of operating.

MOTION.—Dr. Poulton drew the attention of the members to the recent action of the City Council, in proposing to abolish the appointment of Medical Officer of Health, and substituting in his place an Analytical Chemist. He considered that it was quite unnecessary in addressing a medical audience to dwell upon the extreme undesirability of such a step. The propriety of the post of Health Officer being held by a medical man had never, he believed, been questioned by the medical profession; nor would it be allowed that a man devoid of such medical knowledge as the holding of a diploma or degree implies, can discharge efficiently

the duties of a medical officer of health. He continued: it is no doubt desirable that a health officer should have the services of experts at his disposal, and he will at times require reports from the sanitary engineer, the analytical chemist, and other specialists; but who other than a medical man can wisely advise a board of health on all the subjects affecting the hygiene of a community, for he requires, as indicated by the Local Government Board of London, a knowledge of all the influences affecting or threatening to affect injuriously the public health in his district. It is his function to enquire into and ascertain the causes, origin and distribution of disease, and to institute steps for their removal or mitigation. He must be able to advise the sanitary authorities on all matters affecting the health of his district, and his certificate as a medical man is necessary as the basis of sanitary action; and he must be competent to advise his board with reference to the outbreak of infectious disease, to the overcrowding of tenements, to the wholesomeness of marketable goods, to the offensiveness or danger of any process of trade, &c., &c. For the performance of these and other functions of the office, no other professional man is fitting or competent, but a medical man. To propose a barrister for the post of health officer would be as fitting or reasonable as an analytical or any other chemist. In this colony, with its recognition of unqualified practitioners, its array of unqualified vaccinators, with a registration of deaths accepting certificates from men with qualifications (if any), and without if none, it is incumbent upon this branch of the British Medical Association to oppose any step, however trifling, towards the public discredit of a profession taking, as it does, by no means its proper position in the governance of public affairs. He should therefore move, that the South Australian Branch of the British Medical Association, views with apprehension the proposal of the City Council to appoint an analytical chemist as Health Officer of the City of Adelaide; and expresses its decided opinion that the post should continue to be held by a legally qualified medical practitioner.

The PRESIDENT having expressed a doubt as to its being in order to take the motion, seeing that no notice had been given,

Mr. HAYWARD moved, on the ground of urgency, that the matter be discussed, and a course of action decided upon at that meeting.

Dr. CAWLEY seconded the motion, which was carried.

Dr. THOMAS, in seconding Dr. Poulton's motion, said he quite agreed with the sentiments that had been expressed.

Mr. CLINDENING thought that the action of the City Council was unprecedented. It was never so in England, all health officers being medical men. The late Dr. Letheby, health officer of the City of London, was indeed a great chemist, but still he was a medical man as well.

The subject was referred to the Council for it to take immediate action thereon.

A somewhat lengthy discussion then took place upon "Hydatid of the Lung," and the "Case of Death, following the inhalation of ether, at the Adelaide Hospital," commented upon in the editorial columns of our November issue.

PATHOLOGICAL SPECIMENS, exhibited by Dr. Poulton. (a), kidneys from a young adult male, showing acute desquamative nephritis; (b), heart, showing aortic stenosis and disease of the mitral valves. Exhibited by Dr. Gardner (a), foot showing sarcoma, for which Syme's amputation had been done; (b), the lymphadenomata removed from the right and left sides of the neck in the patient exhibited.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, JANUARY 15, 1885.

EDITORIALS.

VACCINATION.

A DISCUSSION on the advantages and evils of vaccination has recently taken place in the columns of the *Sydney Morning Herald*, in which Drs. Brereton, Ashburton Thompson, and Macarthy took part. The champion of the anti-vaccinationists is, of course, Dr. Brereton, who evidently in his quotations of authorities and statistics has to the fullest extent availed himself of that license and play of fancy which is the privilege characteristic of a poet. This was made very obvious by the letters of Dr. Ashburton Thompson, and also by that of Dr. Macarthy, who has made good use of the facts so ably compiled by Mr. Ernest Hart in his pamphlet entitled "The Truth about Vaccination," and has done useful work by bringing them in his letter within the reach of the public in Australia. We think that he would have added force to his letter had he quoted from the same work the report of the Select Committee of the House of Commons, which comprised gentlemen of all shades of opinion on the subject, and who, as the result of their enquiries, say—

"Eight sittings of your Committee have been occupied in hearing the evidence of persons who assert that vaccination is useless and injurious, and who therefore object to its enforcement and encouragement by the law." After careful consideration of this evidence and of medical and other evidence given in reply, your committee agree with the general opinion:—

"That the cowpox affords, if not an absolute, yet a very great protection against an attack of

smallpox, and an almost absolute protection against death from that disease.

That if the operation be performed with due regard to the health of the person vaccinated, and with proper precautions in obtaining and using the vaccine lymph, there need be no apprehension that vaccination will injure health or communicate any disease. That smallpox unchecked by vaccination is one of the most terrible and destructive of diseases, as regards the danger of infection, the proportion of deaths among those attacked, and the permanent injury to the survivors; and therefore, that it is the duty of the State to endeavour to secure the careful vaccination of the whole population.

Your committee have no doubt that the almost universal opinion of medical science and authority, is in accordance with Dr. Gull, when he states that "Vaccination is as protective against smallpox as smallpox itself;" with Dr. West, when he gives as the result of his experience as physician to the Children's Hospital in Great Ormond Street, and as having had charge of between 50,000 and 60,000 children since 1835, that "he does not think that vaccination does produce disease," and with Sir William Jenner, when he says, "I should think myself wicked, and really guilty of a crime, if I did not recommend every parent to have his child vaccinated early in life."

Against this evidence in favour of vaccination the prevalence of the present smallpox epidemic, especially in the metropolis, has been alleged. Your committee, however, believe that, on the one hand, if vaccination had not been general, this epidemic might have become a pestilence as destructive as smallpox has often been where the population has been unprotected; and that, on the other hand, if this preventive had been universal, the epidemic could not have approached its present extent."

The experience of our readers will, we think, agree with this report; for ourselves, personally, we can but say, that having acted for three years as public vaccinator in one of the largest and poorest districts in London, and having vaccinated many hundreds of individuals of all ages since then, we have never seen any single instance in which any bad result followed the operation. It is remarkable as showing how little justification there is for

conscientious dissent from the truth of the usefulness of vaccination, that in the ranks of the anti-vaccinationists in Europe there is no single individual belonging to the profession who has gained creditable notoriety—we do not say celebrity—in any other way than by his opposition in this matter to the carefully considered and frequently expressed opinions of the leading spirits in medical science. A short article in the *Herald* of January 9 accuses Dr. Thompson of wishing to prevent free discussion on the subject, but we do not think there is any valid ground for this charge, for we know that he thinks as we do, that the freer the discussion the greater probability there is of the great majority of the people being convinced of the benefits of the discovery of the immortal Jenner. No doubt he did protest against the publication of clipped quotations and distorted facts without due consideration by a leading newspaper. This article, evidently the offspring of the principal editor, is vague and disconnected, and shows a singular independence of philology, especially when it says, in speaking of the people, "They are not to be *diagnosed into medical treatment*; a free people should comply with the law approvingly," which is, to say the least, remarkable in a LL.D. whose literary merits, learning and profound wisdom are so frequently and respectfully lauded by his awe-stricken but very select band of admirers.

SMALL POX PROSECUTIONS IN SYDNEY.

DR. DONOVAN having been convicted on December 11, under the Contagious Diseases Supervision Act, of having neglected to report a case of variola which he had been attending, pleaded guilty on December 16 to three other charges of a similar nature and was again fined £50, with costs in each case. The heliotype illustrations which we published with our last issue were from photographs taken from two of these cases, and they show such typical cases of variola that after seeing them we do not think any of our readers will question the justice of Dr. Donovan's conviction. In an unvaccinated community, such as New South Wales, where there is no compulsory vaccination act, and where voluntary vaccination, in consequence of the ignorant prejudice and indifference of many of the people is so inadequate to combat the evils of a small pox epidemic, it is essential that outbreaks of the disease should be promptly reported to the authorities to enable them at once to isolate all persons likely to

spread infection. This desirable state of affairs was entirely thwarted by the culpable neglect of Dr. Donovan, who in his entire conduct in these cases has exhibited either such gross ignorance of the pathology of variola, or failing this, such moral perversity as to bring in the public mind, great discredit on the profession of which he is a member. One case might be overlooked in the hurry of practice, by a worthy practitioner, but four occurring at the same time should, it would be thought, have aroused the suspicion or conscience of any man who had received a proper professional training. The chief lesson to be taught by the incident appears to us to be, that it shows how essential it is to the public interest to have fitting legislation for the regulation of medical practice in New South Wales. Under a proper Medical Act a medical practitioner guilty of such an offence might be suspended from practice for a greater or less time as his error deserved, and this would have happened to Dr. Donovan had he practised in the State of Illinois, for but a short time since a practitioner in that State was for ever removed from the register of medical practitioners for his failure to report a single case of variola which he was attending. In this colony similar action is taken against a master mariner should he lose or risk his ship and his passengers' lives through ignorance or carelessness, and in return he is protected from the rivalry of men who have not received a proper training, and who have not proved their capability by the passing of the necessary examinations.

ALLEGED ANTIDOTE FOR SNAKE POISON.

RECENTLY, in Tasmania, a working-man, named James Phillips, asserted that he had discovered an antidote for snake poison, and that his antidote was derived from herbs growing in the bush. His earlier experiments, tried before non-professionally trained men, were so apparently successful as to arouse some attention, but on their being repeated under the supervision of the Curator of the Hobart Museum, Mr. Morton, and in the presence of some members of the profession, it was shown that the antidote had no curative effect, the animals subject to the poison dying as quickly when it was applied as when it was not. If the description of the manner in which the antidote was used by the discoverer is correct, it is not likely to do any good, for none was thrown into the system or brought into intimate contact with the venom, but it was merely rubbed on the skin about the wound, a manifestly insufficient

method of using it. We fear that, like all antidotes for snake bites hitherto brought forward, this will prove, with the rest, of no potency or value. The report shows a regrettable uncertainty in the popular nomenclature of snakes in the various colonies, for the *Hoplocephalus superbus*, an extremely deadly reptile, is called the "diamond snake," whilst, in New South Wales, the *Diemenia superciliosa*, a non-venomous one, is also called the diamond snake. In Tasmania, again, the *Hoplocephalus curtus*, probably the most deadly of all Australian snakes, is known as the black snake, whilst, in New South Wales, the *Pseudechis Porphyriacus* has that name, a reptile which is no doubt dangerously venomous, but yet not nearly so deadly as the *Hoplocephalus curtus*, which, in the latter colony, is known as the brown banded snake.

As we think such superhuman genius should not pass unrecognized, we print the following advertisement from the "Hughenden Ensign," Northern Queensland, for the criticism of our readers. We fear, however, that we shall raise unworthy feelings of envy at the uninterrupted success of this, by his own account, unrivalled practitioner :-

Dr. A. E. BYRN,

PHYSICIAN, SURGEON, OCULIST,
ACCOUCHEUR & APOTHECARY.

LATE of Victoria and Northern Queensland, is the only Surgeon in all the Colonies who treated forty-seven cases of Diphtheria without a single death, or performed all kinds of operations without one mishap during a continuous Hospital practice of seventeen years. Also, Surgeon for 12 years to five Societies, numbering over 1600 in families (see their Stamped Testimonials)

Hughenden.

REPORTS OF SOCIETIES.

Medical Section of the Royal Society of N. S. W.

A GENERAL meeting of the medical section of the Royal Society was held on Friday evening, December 19, Dr. M'Laurin in the chair. Owing to unavoidable causes, two gentlemen who were to have read papers were unable to attend. Dr. Jenkins exhibited two men who were struck by lightning two months ago, whose cases present points of very considerable interest, and are under observation in the Prince Alfred Hospital. A committee was appointed, at the instance of Dr. Belgrave, consisting of Dr. Manning, Dr. Scot Skirving, Dr. Foreman, and himself, to inquire into the properties of the carica papayn as a medicinal agent. Dr. Goode exhibited plaster-casts of stumps resulting from the "coat-sleeve" method of amputating. A discussion followed. The secretary, for Dr. Cosby Morgan, of Newcastle, read a paper on a case of "hydatid cyst of the liver," which ruptured and caused death, and which from the conditions connected with it was of special interest. The meeting then terminated.

LEADING ARTICLE.

PAGET'S DISEASE OF THE NIPPLE.

By H. MARSHALL FENWICK, M.B., L.R.C.P.,
M.R.C.S., ENG., OF CARLTON, MELBOURNE.

IN Vol. X. of St. Bartholomew's Hospital Reports, Sir James Paget called attention to the hitherto unobserved fact that the discovery of malignant disease of the breast is often preceded by the appearance of an eruption on the nipple and surrounding areola, resembling eczema or psoriasis in character, and exceedingly obstinate to treatment.

The physiological or pathological relations of the eczematoid eruption to the neoplasm are as yet undetermined.

At the time of publishing his paper Paget had seen some fifteen cases of this mamillar and areolar eruption, and in all these cases treatment was found to be of no avail, the eruption persisting until the development of the neoplasm in the mamma, an event which was found to occur in a period of time varying in duration from a few months to two or three years from the date of the first appearance of the eruption. The new growth was never observed to originate in the mamilla, but always in some distant part of the breast, the

nipple remaining unaffected until the disease had been allowed to make considerable progress. In all cases of this malady Paget recommends the diseased tissues to be extirpated by the knife or caustics—by the former method preferably—before the cancer shall have manifested itself; and this course should be all the more urgently insisted upon if there should be a history of malignant disease in the patient's family.

As Paget's disease of the nipple is comparatively rare, and as a correct diagnosis is of the utmost importance in view of extirpation as the most appropriate treatment, I desire to draw attention to a few points of diagnostic importance which I have deduced from notes of some cases of the disease I have had the opportunity of watching for some considerable time.

The several morbid conditions of the nipple and areola which might be mistaken for Paget's disease are, eczema, psoriasis, herpetic eruptions, "fissures and cracks," earliest stage of epithelioma or lupus, and syphilitic ulceration.

I need only treat here of the differential diagnosis of Paget's disease from eczema, herpetic eruptions, and syphilitic ulceration, as the true nature of any of the other conditions would probably be made out by any but the most cursory examination.

PAGET'S DISEASE :

ECZEMA OF THE
NIPPLE :

1. May occur at any age after puberty, but most commonly between the ages of 40 and 50.
2. Has only been observed in females.
3. Seems to have no connection with suckling, occurring as often in women who have never suckled as in those who have.
4. Although generally occurring soon after cessation of the catamenia, that circumstance does not seem to bear towards Paget's disease a causal relationship.
5. At first sight the nipple and part of
1. May occur at any age, but most commonly between the ages of 20-35.
2. Although generally occurring in females, yet is sometimes observed in males.
3. Generally occurs during lactation or pregnancy, but is sometimes due to neglected scabies.
4. Generally occurs before the cessation of catamenia.
5. Affected part not nearly of such a bright

HERPETIC ERUPTION
(rarely confined to nipple
and adjacent areola) :

1. Occurs most commonly about puberty.

SYPHILITIC ULCERATION :

1. May occur at any age.
2. May occur in males.
3. No necessary relation to pregnancy or lactation. Usually some concomitant obviously syphilitic manifestations.
4. No relation to catamenia.
2. Occurs in males as well as in females.
3. Occurs generally as the result of a chill, or as a symptom of one of the acute fevers. Sometimes observed in parturient women.
4. Generally occurs long before cessation of catamenia.
5. Still less accompanying erythema than in

- the areola seem to be covered with an eruption resembling a mixture of eczema and syphilitic psoriasis. Surrounding the affected parts is a zone of erythema.
6. After the removal of the eczema-like crusts the affected surface is bright red, raw looking, and of a markedly granular appearance, somewhat "strawberry-like."
7. The eruption is abruptly defined and raised above the surrounding surface.
8. On palpation a peculiar limited superficial induration is perceived.
9. There is no constant pain, but on grasping the nipple an acute neuralgic pain shoots through the breast.
10. Result of treatment: Uninfluenced in progress by the administration internally of the usual remedies for eczema and psoriasis, and by the usual external application. Unless extirpated by the knife or escharotics cancer appears in from 4 months to 2 or 3 years after first noticing the eruption.
- red tint as is the case in Paget's disease.
- eczema.
- appearance, characteristic of Paget's disease.
6. Nipple and adjacent areola are denuded of epithelium, swollen, and moist, covered partly with recent vesicular eruptions, and partly with brownish scabs under which either healing goes on or increased secretion which oozes under the scab and is accompanied by severe itching. After removal of crusts surface slightly irregular, but not granular.
7. Eruption irregular in distribution, and is not raised above the surrounding surface.
8. No induration.
9. Constant itching, sometimes almost unbearable.
10. Most cases yield to ordinary treatment for eczema, but some few prove obstinate. The latter may generally be cured by painting affected part once or twice with a solution of silver nitrate, 15 gr. ad. 1 ounce, after having removed the scabs by applying a soft poultice.
6. Eruption, rarely confined to nipple and adjacent areola, consists of small papules which rapidly become vesicular, containing clear fluid, which afterwards becomes turbid. These vesicles either burst or more commonly are broken by scratching, and scabs are formed.
7. Eruption usually extends over whole breast in some direction.
8. Induration according to the amount of irritation from rubbing or scratching. If much irritated, small ulcers with thin scabs and indurated margins are formed, sometimes difficult to distinguish from syphilitic chancres.
9. Eruption is preceded by burning pain, which is soon lost. Considerable itching, however, usually persists.
10. Usually heals up rapidly under boro-glyceride application.
6. Usually shallow, clean cut, serpiginous ulcer, with indurated edges.
7. —
8. Edges of ulcer always indurated.
9. No pain.
10. Heals under use of iodoform locally, and anti-syphilitic remedies internally. Other signs of venereal infection will probably appear later on.

THE MONTH.

NEW SOUTH WALES.

AT the Water Police Court, Sydney, on December 10, Dr. James Donovan, of Hyde Park, was charged by the Board of Health under the Infectious Diseases Suppression Act with failing to report a case of eruptive fever reasonably supposed to be smallpox. Drs. Mackellar, Ashburton Thompson, and Sibley, were examined for the prosecution, and Drs. Warren, Roth, and McCarthy for the defence, after which, Mr. Johnson, D.S.M., who occupied the bench, said he considered the case had been fully proved against the defendant. He inflicted the highest penalty, viz., £50, in default three months' imprisonment. Notice of appeal was given. He was again prosecuted at the Water Police Court on December 16, for neglecting to report three other cases of smallpox which had come under his treatment. Defendant pleaded guilty, and in each instance he was fined in the sum of £50, with 5s. 6d. costs, or in default three months' imprisonment.

Two cases of smallpox have occurred at Moss Vale, 86 miles S. of Sydney, and five fresh cases have been reported from Balmain and Waterloo, suburbs of Sydney.

IT is the intention of Sir Alfred Roberts to proceed to Europe this month, and to enable him to do so without forfeiting his public appointments, the Executive Council have granted him 12 months' leave of absence, to commence on the 1st February next. Dr. Mac Laurin will act as locum tenens during the term of Sir Alfred's absence from the colony.

A BANQUET was given to Dr. H. Tarrant, M.L.A., of Sydney, by his constituents at Kiama, on January 7.

DR. W. J. BARKAS has removed from 300 Oxford street to 51 Regent street, Paddington.

DR. WAZIR BEG, M.D., LL.D., M.R.C.S.E., a well-known Presbyterian minister, died at his residence, 139 Forbes street, Woolloomooloo, Sydney, on January 4, at the age of 58 years. The deceased gentleman never practised the medical profession, which he studied at the Edinburgh University.

DR. A. C. BROWNLESS, late of Nymagee, has succeeded to the practice of Dr. G. J. Renwick, of Hyde Park, Sydney.

THE Hon. Joseph Docker, M.R.C.S., Eng., 1824. L.S.A., Lond., 1832, M.L.C., died at his residence, St. John's Terrace, Darlinghurst road, Sydney, on December 11, in his 83rd year. The honourable gentleman, who in the early part of his life was a surgeon in the East India Company's navy, came to New South Wales in the year 1834, as surgeon superintendent on board the female immigrant ship "David Scott." Mr. Docker, determining to remain here, settled on the Hunter River, where he filled the office of warden for the district of Scone. Subsequently he became a member of the Legislative Council, and, in 1866, Postmaster-General. In 1868, he was appointed to the office of Colonial Secretary, and in 1870 Mr. Docker again became Postmaster-General, and remained in office until May, 1872. In 1875 he was Minister of Justice and Public Instruction, and latterly he filled the office of Chairman of Committees in the Upper House.

DR. J. B. GRAHAM, a new arrival, has settled at Gulgong, a mining township, 200 miles W. of Sydney.

DR. JAMES MITCHELL has succeeded to the practice of Dr. A. Barber, at Narrandera, the centre of a large pastoral district on the Murrumbidgee River, 348 miles S.W. of Sydney.

DR. J. J. O'DWYER desires us to state that he holds the appointment as Surgeon to the Gundagai Hospital.

DR. WILLIAM HALL PALMER, M.D., Edin., 1829, M.R.C.S., Eng., 1830, died at his residence, "Cheverella," Elizabeth Bay road, Sydney, on December 10, in his 81st year.

DR. C. E. ROWLING, of Parramatta, has been appointed Visiting Medical Officer to the Prospect Camp, near that town, at a salary of £312 per annum.

MR. EDMUND SAGER, secretary to the Health Department, has also been appointed secretary to the Medical Adviser to the Government.

DR. J. C. SOUTER, of Gulgong, has succeeded to Dr. R. McDougall's practice at Murrumburrah.

NEW ZEALAND.

WE understand that Dr. Hocken, of Dunedin, has refused to retire from the office of coroner when requested to do so by the Government, in accordance with a resolution of the House passed last session, to the effect that medical men in practice should not hold the office of coroner. Other medical men holding a similar position, to whom the request was made, have most of them, it is said, complied.

DR. T. HOPE LEWIS, a valued contributor to the *A.M.G.*, whose term of engagement with the Government of New Zealand, as Resident Medical Officer in the Hot Springs district, expired on December 31st last, has left Rotorua and commenced practice in Grafton road, Auckland; his successor is Dr. A. Ginders, late of Tauranga. Dr. Lewis intends publishing a short medical guide to the Rotorua district, so that what experience he has gained during his three years' residence there, may be of some service to the profession and public generally.

DR. G. P. RICHARDS, late of Hawera and Waitara, has removed to Palmerston North, in an agricultural district, 96 miles N. of Wellington.

QUEENSLAND.

THE Immigration Board have held an inquiry into a number of complaints which have been brought by the passengers of the "Duke of Westminster" against the surgeon superintendent, Dr. Marks. The evidence was very conflicting. The captain, who had made four voyages with Marks with immigrants, gave him a very high character in all respects. The matron gave similar evidence, and said that the charge arose out of spite, in consequence of the accused's determination to maintain discipline.

TENDERS have been invited for the erection of a new hospital, in brick, at Maryborough; also for a hospital at Charleville, on the Warrego river, in a pastoral district, 520 miles W. of Brisbane.

THE Medical Institute in Brisbane, projected by the associated friendly societies, was opened on January 2. Sixteen lodges are represented in the management of the institution, and already 1300 names are on the books.

DR. R. RENDLE, of Brisbane, and Mr. Ph. Pinnock have been appointed Official Visitors to the Hospital for the Insane at Goodna, and Dr. H. M. Lightoller, of Ipswich, and Mr. Wm. Yaldwyn, to be Official Visitors to the Hospital for the Insane at Sandy Gallop.

DR. EDWARD HORAN, a new arrival, has commenced practice at Charters Towers.

MR. GEO. H. NEWMAN has been appointed Curator in Insanity for Queensland.

SOUTH AUSTRALIA.

At the commemoration held at the Adelaide University on December 16, the Chancellor Chief Justice Way conferred the degree of M.D. (ad eundem gradum) on Benjamin Poulton, M.D., of the Melbourne University, and the degree of M.B. on H. Sanderson Lloyd, M.B. of the University of Edinburgh, and Chas. August Altmann, M.B., of the University of Melbourne.

DR. GOSSE, president of the local branch of the British Medical Association, has forwarded a copy of a resolution carried at a meeting of the association, expressing apprehension at the proposal of the City Council to appoint an analytical chemist as health-officer for the city, as they consider the post should be filled by a duly qualified medical practitioner. The Central Board of Health also objects to the proposal of the City Council.

DR. ARCHIBALD WATSON, M.D., F.R.C.S., and Senior Demonstrator of Anatomy at the Charing Cross Medical School, has been appointed Professor of Anatomy in the Adelaide University.

DR. C. F. BURTON, late of East Peckham (Kent), has settled at Snowtown, the centre of an agricultural and pastoral district, 92 miles N. of Adelaide.

ROBERT WATERS MOORE, M.R.C.S.E., President of the Medical Board, died at his residence, North Terrace, Adelaide, on Saturday, December 6, after a painful and prolonged illness. He was born at Cork, 1819, and began the study of medicine at the Southern Infirmary in 1835. He removed thence to London and entered at Charing Cross where he was sometime demonstrator of anatomy. He became a M.R.C.S. in 1842, went to Paris and completed his studies there. He took emigrants out to Sydney in 1846 and arrived in S. A. in 1847, settling for a time at the Burra copper fields, but eventually took up his residence in Adelaide, and in 1858, on the resignation of the late Dr. Gosse, was made Colonial Surgeon. He held this office until 1869, and has since been engaged in private practice. He was an accomplished classical scholar; had some acquaintance with Hindostanee and Chinese, was a botanist, and a Fellow of the Linnean Society.

DR. ROBERT PEEL, of Melbourne, was entertained, on January 7, at a dinner at the South Australian Club Hotel, Adelaide, by his old friends, including gentlemen who have been connected with him in the City Council.

DR. PERCY WOODS, of Yam Creek, has been appointed Health Officer and Protector of Aborigines for the Northern Territory, vice Dr. Morice, resigned.

VICTORIA.

At a meeting of the Faculty of Medicine of the Melbourne University, held on December 20, to consider the letter received from a number of third year medical students, making certain complaints against Mr. T. M. Girdlestone, the lecturer on surgery, and also the reply of that gentleman, which was published in the November issue of the *A.M.G.*, it was resolved "that the explanation of the lecturer on clinical surgery is considered perfectly satisfactory."

At a recent meeting of the Central Board of Health the Social Evil and its attendant diseases were referred to. It was decided that the Chief Secretary should be requested to take immediate action to improve the present condition of affairs.

THE annual report of the Committee of the Geelong Infirmary and Benevolent Asylum shows that, during the past year, 2,805 cases had received relief, viz., 665

indoor patients, 131 inmates of the Benevolent Asylum, and 2,009 out-door patients. Of the hospital patients, 559 were discharged, 69 died, and 47 were under treatment on the 31st December. Of the Benevolent inmates, 22 were discharged or left, 16 died, and 92 remained in the house. The daily average had been 145. The average mortality was 9·4 per cent. The total number in the house on the 31st December was 139. Drs. D. B. Reid, P. A. Croker, C. E. Wyer, and E. J. Walshe have been elected the honorary medical staff for the ensuing year.

A DAIRYMAN at Melbourne has been fined £10, and another dairyman £20 for selling adulterated milk.

THE last of the smallpox patients were discharged from the Melbourne Sanatorium on December 16.

A CASE of small-pox has occurred at Castlemaine, also at Hotham, a suburb adjoining Melbourne.

MEASLES are prevalent at Avoca.

DR. J. D. COLLIER has settled at Maryborough, and Dr. W. J. Bird at Coburg.

DR. ALBIN LURZ, a new arrival, has commenced practice at 36 Russell street, Melbourne, as a specialist in Electrotherapy, Massage and Swedish gymnastics.

DR. L. A. NOLAN has settled at Dandenong, and Dr. W. Gillespie at Corryong; both gentlemen are new arrivals in the colony.

DR. JOSEPH KNIGHT BARNETT, M.D., St. And., 1857, M.R.C.S.E., 1855, Public Vaccinator for Tintaldra (Vic.), also for Tooma and Tumberumba (N.S.W.), the oldest practitioner in the Border district, died at Tintaldra on January 5. Dr. Barnett served through the Crimean campaign, and at one time held the appointment of Medical Officer to the Young Hospital (N.S.W.).

CORRESPONDENCE.

CORONERS AND MEDICAL ETIQUETTE.

To the Editor of The A.M.G.

SIR,—The editor of our local journal has noticed and published a letter which appeared in your *Medical Gazette* of this month. This letter, from its subscribed initials and general tenor, he evidently, and with apparent good reason, considers as applicable to the district, but more particularly to myself as coroner.

The paragraph runs as follows:—

"We take the following correspondence from the *Australasian Medical Gazette* of this month. The 'initials are obviously of local application.'"

Your remarks towards the close as replying to the correspondent, R. J. A., would be correct were the circumstances correctly placed before you, but the following version of the case (which is the one undoubtedly referred to by R. J. A.) places the matter in a very different light, and completely justifies my action both in regard to professional etiquette and my discretionary power as Coroner:

A was called in at 2 a.m., and finding the man dead, returned home. The principal witness at the inquest in her evidence stated about six months previous the Government Medical Officer, B, had attended deceased, and from her and the Government doctor's evidence, the jury considered a post mortem examination unnecessary, and not required to enable them to arrive at a verdict, consequently *no post mortem* took place.

Yours, &c.,

Raymond Terrace, W. E. SHAW, Coroner.
Dec. 29, 1884.

OBITUARY.

WILLIAM GILLBEE, M.R.C.S., ENG.

It is with feelings of regret that we record the death of Mr. William Gillbee, one of the oldest practitioners of Melbourne, who expired at the residence of Dr. Brownless, 14 Albert Street, East Melbourne, on January 4, aged 60 years. The deceased gentleman was a native of Hackney, near London, and his medical education was pursued for the most part in Edinburgh. He became a member of the Royal College of Surgeons of England in 1848, and in the following year he visited Tasmania and Victoria, the latter then Port Phillip; but hearing of the gold discoveries in California, he proceeded thither, and for two years passed an adventurous time in the wild gold-fields of that country. Returning to England, he took ship again for this part of the world, coming out in medical charge of 500 emigrants in the "Georgiana," whose destination was Geelong, where, in consequence of a mutiny among the sailors, he had a somewhat perilous experience from his assisting the captain to suppress the insubordination of the men. As he had had enough of diggings experience in California, he had no curiosity to see those of this country, but came straight on to Melbourne, where he at once commenced practice, in which he was actively engaged for 30 years. In the early part of 1854 he was elected surgeon to the Melbourne Hospital—then about one-tenth of its present size. With this institution his professional life was closely identified, and in every movement made to enlarge and improve it he took a very active share. He held the position of Honorary Surgeon to the institution for 22 years, till the election of 1875, when he was not one of the successful candidates. He, however, retained his place in the committee of the hospital, and in 1877 became its vice-president, and in 1882 its president. In 1853 he assisted in the formation of the Medical Society of Victoria, of which, 10 years later, he became president. In 1879 he warmly assisted in the formation of the Victorian branch of the British Medical Association, and was elected its first president. In 1872 he was elected by a vote of the whole profession to a seat on the Medical Board of Victoria, and on the retirement of Dr. M'Crea, about six years ago, he was appointed its president, which office he held at the time of his death.

Mr. Gillbee was among the first, in 1853, to encourage the volunteer movement, and he was the first assistant-surgeon appointed. In the interest he felt in this institution he never relaxed, and eventually he became the medical head of the force, with the rank of lieutenant-colonel, a position he ceased to hold only a little while before he gave up the active duties of his profession. In 1861, being then one of the vice-presidents of the Royal Society of Victoria, he was actively concerned in the proceedings of that body with reference to the Burke and Wills exploring expedition. His visit to the old country, taken in November, 1883, in the hope of deriving some benefit from the rest and change of scene, was unattended by any benefit whatever, and it was feared when he embarked on the return voyage, some three months ago, that he would never reach Melbourne. The lung disease, which carried him off, commenced about two years ago, and although he gave up his practice and did what he could to recover his health, it was of no avail.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Ross, Elsie Fairfax, M.R.C.S., Eng., 1884; L.R.C.P., Lond., 1884; M.D., Bruxelles, 1884.
Harbison, John Wesley, M.B. & Ch. B., Melb., 1882.

QUEENSLAND.

Ellison, John Clement, M.B., Lond., 1882; M.R.C.S., Eng., 1881.
Sherit, Charles Augustus.
Owens, Edward Matthews, F. & M.R.C.S., Eng., 1866; L.R.C.P., Edin., 1867; L.S.A., Lond., 1866. (For three months from December 4.)

VICTORIA.

Service, John, L. & L. Mid., R.C.P. & R.C.S., Edin., 1878.
McFarlane, Colin Campbell, L. & L. Mid., R.C.S. & R.C.P., Edin., 1884.
Lang, William Henry, M.B. & Ch. M., Edin., 1882.
Gillespie, William, L. & L. Mid., R.C.S., 1878, & R.C.P., Edin., 1882; F.R.C.S. Edin., 1883.
Nolan, Lyster Andrew, L. & L. Mid., K.Q.C.P., Irel., 1881; L.R.C.S., Irel., 1872.
Bird, William Joshua, M.B., Melb., 1884.
Collier, John David, L.R.C.S., Irel., 1876; L.K.Q.C.P., Irel., 1879.
Flett, William Simpson, M.B. & Ch. M., L. & L. Mid., R.C.P. & R.C.S., Edin., 1883.
Hewer, Henry John, M.R.C.S., Eng., & L.S.A., Lond., 1884.
Lurz, Albin, M.D., Wurzb., 1872; State's Exam., Munic., 1872.
Nickoll, Edward Harvey Bird, L. & L. Mid., R.C.P. & R.C.S., Edin., 1883.

MEDICAL APPOINTMENTS.

Allan, Robert John, L.R.C.P., Ed., M.R.C.S.E., to be Public Vaccinator for Raymond Terrace, N.S.W.
Burton, Charles Frederic, L.S.A., Lond., to be Public Vaccinator at Snowtown, S.A.
Curtayne, Herbert Maxwell, M.B.C.S.E., to be Public Vaccinator for the District of Granville, N.S.W.
Gosse, Charles, M.D. & Ch. M., Aberd., M.R.C.S.E., to be a member of the South Australian Medical Board.
Hogg, James Ballantyne, L.R.C.P. & R.C.S. Edin., to be Assistant-Superintendent of the Hospitals for the Insane at Goodna and Sandy Gallop, Qu.
Low, Charles, M.B. & Ch. M., Edin., appointed Resident Medical Officer at the Southland Hospital, Invercargill, N.Z., vice Dr. Wardale, resigned.
Miller, William Francis, M.B. & Ch. B., Melb., L.R.C.P. & R.C.S., Edin., M.R.C.S.E., to be Health Officer for Maryborough, Vic.
Reid, John, Surgeon, to be Public Vaccinator at Port Germein, S.A.
Roberts, Arthur Henry, L.R.C.P., Lond., M.R.C.S.E., appointed Resident Medical Officer at the Prince Alfred Hospital, Sydney.
Ryan, John Pennafather, L.R.C.S., Irel., L.K.Q.C.P., Irel., to be Government Medical Officer at Gympie, Qu., vice Dr. Clough, deceased.
Scholes, Richard Batteraby, M.B. & Ch. M., Edin., to be Inspector of Asylums for the Insane in Queensland, also Superintendent of the Hospitals for the Insane at Goodna and Sandy Gallop, Qu.
Service, John, L.R.C.P. & R.C.S. Ed., to be Resident Medical Superintendent at the Quarantine Station, North Head, Sydney, N.S.W.
Smith, Frederick Moore, M.R.C.S.E., M.D., to be Resident Medical Superintendent of the Coast Hospital, at Little Bay, near Sydney, vice Dr. Violette, resigned.
West, William Augustus, L.R.C.S., Irel., L.K.Q.C.P., Irel., appointed District Surgeon of the Sydney Hospital.

REPORTED MORTALITY FOR THE MONTH OF NOVEMBER, 1884.

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* The Official Monthly Report on the Vital Statistics of Brisbane and Suburbs does not show the number of deaths from the various diseases.
† The population of N. S. Wales, Queensland, and Adelaide is that of the census of 1881; New Zealand, South Australia, Tasmania and Victoria show the estimated population at the present date.

METEOROLOGICAL OBSERVATIONS FOR NOVEMBER, 1884.

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AUSTRALASIAN MEDICAL GAZETTE.

CLINICAL LECTURE.

CASE OF TRANCE IN A CHILD, CULMINATING IN ECSTASY AND HYSTERIA.

DELIVERED AT THE MELBOURNE HOSPITAL BY
J. W. SPRINGTHORPE, M.A., M.D., MELB.,
M.R.C.P., LOND., HON. PHYSICIAN TO THE
HOSPITAL.

E—P—is a happy little girl, aged 10 years, very sensitive and emotional, but without any organic disease detectable. From her parents she inherits neurotic and possibly tubercular tendencies. Her great grandfather had a paralytic stroke, his grand daughter was epileptic, and the girl's own father was a drinker. The mother was married at 17, had two healthy children in the first two years, has buried the subsequent four from marasmus, and last month herself died of an attack of acute phthisis.

The child herself was a strong baby, born at full time, 16 months after the first, and the confinement was not a difficult one. There were no fits during teething, but, at the age of 20 months, she experienced an attack of sunstroke, followed by a convulsive attack; there was no chorea, or subsequent fits, but at 7 years of age she had a very severe attack of pertussis, lasting 6 months, with frequent bleedings from mouth, ears, and nose simultaneously. With the exception that at 8 she had measles mildly, she has otherwise enjoyed very good health. No catamenia have as yet been established.

The present series of attacks began in February, 1883, and at first exhibited nothing but the symptoms of mild trance. The child was up the country on a visit to some friends. One night, after going to bed she was heard breathing heavily; for the space of one hour she could not be roused, though her friends tried ammonia to the nose, shoutings, smackings, painkiller on the tongue, and a warm bath. Next morning, however, she was all right, and knew nothing of what had happened. No particular cause could be given, and sunstroke seems excluded. In the next fortnight two similar attacks occurred about the same time, and of the same duration. No statistics are obtainable between then and December, but some fresh attacks did occur. During the following March, when at home in Collingwood, another seizure took place. When called to get up at 6.45 a.m., she took no notice. Her sister found her lying "just as if asleep," only the lower lip was tremulous, and she could not be woken, though smelling salts, shaking,

smacking, shouting, &c., were all tried—she lay quite calm and warm, without any struggling, and breathing normally; she simply could not be roused for 1½ hour. Another seizure took place on Easter Monday, at the same time and of the same duration; on recovering, she seemed quite well again. Thence onwards to August, she had attacks at intervals of a month. In the first fortnight in August, seven attacks occurred, four of which were within three days, and all lasted about three hours. Not only did the seizures then become more frequent and prolonged, but the character of them now changed: they advanced from the stage of simple trance to that of mild religious ecstasy. This advance may with fair certainty be ascribed to a somewhat extensive acquaintance with the Salvation Army and its excitant methods, which had influenced her nervous system for some little time about this date. Previously she had known nothing of what had occurred, subjectively, or objectively, and the only positive symptom of cerebral action has been an occasional cry upon coming round. On August 11th, however, at 10.15 p.m., without any warning, and after nothing unusual, she was heard snoring; she was found breathing heavily, the lower lip quivering; the tears ran down her cheeks, and she sighed and sobbed fearfully. For the first time, she began to speak—"Oh, dear," "Oh, dear," "How pretty," &c. It was still impossible to rouse her. When asked "what's pretty?" by her mother, she answered "the angel"—to "where?" she replied "in heaven." No other objective phenomenon except the mother's voice seemed able to excite the brain to action. The eyes were closed, but otherwise she lay as if awake and talking in bed. Having said the angel was "like her sister Rosey," she burst out crying, and answered no more. Some time after she cried "Oh, what a pain in my back," and came round, the pain leaving her almost immediately, she seemed quite well, and nothing the matter; no headache, no twitchings. She remembered, however, what had subjectively occurred: how the angels looked, &c., and told her mother she thought she had been dreaming. Objectively, she recollected nothing, not even her mother's voice. A few days previously she had wished to "testify" at a Salvation Army meeting.

The following Friday, August 15, another attack occurred, lasting from 9.45 p.m. to 12.45 p.m. It was similar to the previous one, but more passive. The child said only "Oh, dear," and did not answer questions. Just as she was coming out of it she again complained of pains in the head and stomach, going away almost

immediately afterwards. The next day she seemed drowsy, and at 8.15 p.m., as she sat down to eat, she complained of a pain in the stomach and head, laid her arm on the table and had another seizure, which lasted also three hours, during which she could not be roused. In half-an-hour she spoke as if seeing seven lost relatives and friends in Heaven (all of whom she knew previously.) She spoke to them, and answered questions. Bursting out crying, she said, "Oh, I'm going," "The Saviour is calling me," "Where's my dear mother?" "I can't see you" (without opening the eyes), "I'm going to Heaven." The mother, thinking she was coming round, asked her to have a drink. "No," she replied, "I can't speak," and then went off again, lay perfectly still, and answered nothing. Presently, she started speaking again to her lost relatives: "Oh, you pretty angel," "how pretty you fly;" called "hallo" thirteen times, as if addressing some one; cried "How sweet," as if hearing singing; then saying "The Saviour is calling me," "Good bye, I'm going," "How I long to be with you all," "The angels are all round me," without moving her head, or making any sign. She began to twitch and toss her head on the pillow as if in pain, and came out crying as usual, complaining of pain in head and stomach, and then fell off to sleep. Next morning she seemed as if sickening for something; there was pain in head and stomach, though the appetite was good, and there was no vomiting. In the afternoon, about 3.30 p.m., another attack occurred; she called out as before, adding that she was going that night, and was not to live long. Two days later she had another seizure, the only one in which I was able to see her. She had had a sharp pain across the forehead all day, and in the stomach just before going off. About 8.30 p.m. she went off whilst sitting, and remained unconscious of objective phenomena for one hour. I found her apparently coming round; she lay calm, with the eyes shut, hands sweating, and appeared as if in pain, crying "Oh" at intervals. The pulse was 96, the respirations tranquil, the pupils dilated, equal, and acting sluggishly to light. She answered no questions; both special and general sensation seemed in abeyance; there was no flexibilitas cerea, but at times there were hysteroid convulsions of the muscles of the neck. On touching the ocular conjunctiva she came to herself, complaining of a sharp pain in the stomach, shooting upwards; quickly became quite bright and easily amused. The following Saturday a long seizure occurred, lasting from 11 p.m. to 10 a.m., during which she lay perfectly still.

The character of the attacks now changes again.

The hysteric aspect becomes more pronounced. The religious colouring disappears; her people ascribe this change to attempted mesmerism by a clairvoyant, but probably abstinence from revival influences had something to do with it. Thus on September 2 she had an attack, lasting four hours; in it she plunged about very much, acted as if very frightened, and seemed quite sensible of all that was going on around her, but could not be got to answer questions. She was crying, covering her head, talking gibberish, "Chinese like," incoherently, as if from articulatory chorea. She looked under her eye-lashes, and finally sang herself to sleep "in this strange language." When she came round she maintained that she did not recollect a word of what had occurred. The following morning she was found in a similar state, talking gibberish, with the eyes shut, and still seemed sensible of everything. Thus when her mother wanted to leave she cried for her to come back in this same incoherent manner. The desire for her to stay was evidently present, though the ordinary channel of communicating such desire was disturbed. Again she cried herself out of it, and when it was over, was as jolly and cheerful as usual, and said she knew nothing about it. Three days later she lay in a state of simple trance until 10.30 a.m., the only difference from her original attacks being that water to the face caused a slight cry, without, however, arousing her from her state. The following afternoon, after being spoken sharply to for quarrelling with her brother, she went down the yard to cry, and whilst sitting down with her head leaning against the wall, "went off." She was carried to bed, trance-like, but crying all the while. Water in the face had no effect. Severe hysteroid convulsions followed, and lasted three hours. Opisthotonos was extreme, and the convulsions were general. After an interval of quietness she came out crying, and putting her hand to her ear as if sore. There was blood in the nostrils and throat, and when asked to take a drink she shook her head as if her throat was choked, and she could not speak. She "went on rather strangely before coming right around," and, when apparently recovered, complaining of sickness and frontal pain, she slipped on to the floor, and vomited half a teacupful of dark frothy blood. Half-an-hour afterwards she asked for her tea, and ate it heartily. There was no soreness of tongue or complaints of its having been bitten. The following evening on going to bed, she gave a little cry. She was found lying on her back in bed, plunging about very much, back arched, throwing the arms about, tossing the legs, and working very much with hands and fingers. At times she clutched at her throat; she made no

cry; the eyes were half open. Soon she lay quite still, with feet extended, but kicking when touched; then sensation disappeared, and finally she awoke crying when the eyeball was touched. Between the attacks she takes her food and appears in good health.

On the 11th, 12th, 13th, 14th, and 16th, five fresh attacks took place, all different, but where psychical action was going on, it was still of a hysterical character. On the 11th, after falling asleep at 9 p.m., she began to laugh—to say “How are you, Miss?” “Oh, I’m grand,”—to answer questions, to start half up with eyes partly open, when some one enters the room; things objectively and subjectively seen are confused together. Hearing more voices in the room she says “Good morning, ladies and gentlemen.” She talks to her uncle in an excited manner,—“You’ve insulted me.” She jumps when touched. She speaks with subjective comical old women, &c., laughing and shaking hands all round. This lasted for three hours, and at the end she went off to sleep, and on waking could not be got to confess any knowledge of what had occurred. The next day, at about 12 o’clock, she fell off asleep with a slate in her hand, lay quiet for half-an-hour, and then began as on the previous day—“Good morning, young lady,” and answered questions incongruously. She then seized her mother’s apron, and, saying “Gee up,” kept beating her as a horse for half-an-hour, as if travelling at a great rate. A period of quietness then followed with a natural sleep, from which she awoke as usual quite well, and recollecting nothing about the matter. The next two attacks were similar to her first attacks, except that in one, any attempt to move her caused tetanic rigidity. Two nights afterwards she complained of cold feet, and after sleeping soundly for some time she began to cry in her sleep, the tears falling and the mouth working “as if it were a real cry.” She could not, however, be roused. Soon, she said “Oh, dear, what shall I do?” “I feel so miserable.” Frothing at the mouth, with attempts at vomiting followed; rigidity ensued, when her mother tried to raise her head; finally she vomited half-a-cupful of reddish liquid, and the retching continued for twenty minutes; still she could not be aroused. After a period of quietness she began again—“Oh, dear,” moaned as if in great pain, and was again sick, and again quiet, until she came out of the seizure crying, but without any pain, and as jolly as if nothing had happened. When asked, she said she recollected nothing. This was the last of the series. Thence onwards to the end of the year, the former seizures of simple trance have occurred at intervals of about a month. In the intervals, there is nothing to be

noticed except that the child is very emotional. There does not seem to be any weakness; the functions are all healthily performed, and the influence of the attack apparently ceases when the seizure is over.

REMARKS.—This case is in many ways a remarkable and instructive one. It is very uncommon to find such a congeries of morbid cerebral phenomena in interplay, especially in so young a child, but in the combination of sunstroke and severe whooping cough, acting upon an inherited nervous vulnerability and a systemic delicacy of constitution, we may perhaps claim adequate and efficient causes even for such a rare result. The facts have been critically collected, and may be relied upon, but unfortunately for their fuller value, no opportunity was found for a more scientific examination of their different details. The history of the case, however, as it is, illustrates unusually well several important points in the causation, localization and interconnection of cerebral pathologies. In neurology especially, inheritance is a predisposing cause of disease, and here we have illustrated the influence of epilepsy, paralysis, and drink. Few more potent, exciting causes of nerve troubles exist than sunstroke and whooping cough; and we find both operating in the present case. The case may also be taken as to some extent supporting Grassett’s contention (*Brain*, July, 1884) as to the presence of a tubercular as well as a neurotic element in hysteria, and from his point of view, its future development will be particularly valuable. Regarding the nature of the morbid change, there is food for considerable thought. Underlying all attacks we find there was temporary arrest of special and general sensation, with, at first, an entire absence of all evidence of mental activity. The periodicity of these attacks, their recurrence about the same hour of the day, and their general equality in duration, all favour the theory that the seizures were really explosions of nerve force, occurring at times when nerve tension reached a certain height or fell to a certain level. The minute pathology of trances is insufficiently known to enable us to dogmatize upon the real cerebral status during such attacks, but we may fairly assume that there was a peculiar nervous instability existent, towards which complex sum, an inherited nerve weakness, the vascular changes incident upon sunstroke and whooping cough, and, possibly, also a local scrofulosis, all contributed. That trance resulted and not epilepsy, chorea, or insanity, is probably due to the localization of this functional vulnerability to a certain anatomical stratum, separated it may be, by the depth of a cortical layer, or by the distance of a convolution or lobe. An increased amplitude in range of seizure is evi-

denced when to the dislocation of the ego from objective phenomena are added marked psychical and hysteric phenomena; and a sufficient cause for such extension may be formed in the excitement of an early and intimate Salvation Army experience. Indeed, the case is most interesting as showing the mutual relations between trance, ecstasy, and hysteria. It is interesting further, to notice that as these latter manifestations were as it were "grafted" upon the trance condition, so, too, they are the first to disappear, leaving the primary source of weakness much as it was before they were super-induced.

Regarding the localization much can be said that is probable, and something that is fairly certain. From the tubercular family history, and the previous sunstroke and whooping cough, we might, *primâ facie*, suspect the base of the brain as most probably originating the mischief, and the particulars of the different attacks bear out this assumption very markedly. Some ill-known functional changes occurring in the basal cortex, implicating the posterior fibres of the internal capsule, and extending laterally, by continuity of tissue, to the temporo-spheroidal lobes and angular gyri, would account for all the symptoms of the trance stage; and it is to be noted that occasionally, even when the basal symptoms were marked, extension laterally was shown to be restricted by the partial activity of the optic and auditory centres. The noisy breathing and occasional cry on waking may well be explained by some slight implication of the medulla. With increased excitement follows extension to other parts and implications of wider areas. The pains in the stomach, the vomiting and nausea, the aphonia and globus, the laughter and crying and unintelligible chatterings, the quivering lip, twitching hands, opisthotonos, and general plunging, all are explicable on the assumption that the medulla and connections have become more extensively involved. The tetanic rigidity likewise may arise from implication of the cerebellum, or of the basal ganglia; the hallucinations of sight and hearing from implication of the lateral or frontal cortex; whilst the religious ecstasy and "horsey" talk point to the participation of the anterior cerebral area in the same attacks, resulting in irregular subjective recollections of bygone experiences and acquisitions.

Regarding the ultimate result, a guarded prognosis must be given. With such a history and inheritance, nervous troubles must be anticipated, even under the best treatment and surroundings. For the future it will be well indeed if, after puberty, these go no further than hysteria, and if the hysteria remain of a type fairly under control. The possibility and even probability of tuberculosis in some form or other must not be overlooked.

ORIGINAL ARTICLES.

ON TWO CASES OF CONGENITAL DEFORMITY.

READ BEFORE THE N. S. W. BRANCH B. M. A.

By DAVID COLLINGWOOD, M.D. and B.S., LOND.,
F.R.C.S., ENG., SUMMERHILL, NEAR SYDNEY;
LATE SENIOR DEMONSTRATOR OF ANATOMY
AND PRACTICAL SURGERY AT UNIVERSITY
COLLEGE, LONDON.

It has happened to me, during a very short period of practice in this Colony, to meet with two cases of congenital deformity, and I venture to submit these, together with a few remarks upon them, to the members of the Branch to-night, feeling sure that they will be of interest from several points of view. Each in its own particulars is uncommon and cannot fail therefore to be instructive.

The *first* is a case of deformity, or rather deformities (for they are multiple), in which the conditions were not incompatible with life; and had the child survived, as indeed I at first expected it to do, there would have been opportunity for the exercise of some surgical ingenuity; while in the case of the second child, although it did survive its birth for a few moments, the conditions were essentially incompatible with a prolongation of extra-uterine existence.

The first child was born on the 3rd of October last—I need not detail the circumstances connected with the labour. The child—it was the tenth of the family—and the preceding nine had been perfectly healthy, except to say, that it terminated more quickly than I expected, and the child was born while the mother was in the standing position. At the first glance I saw that it was the subject of a very deep double hare-lip, and was not therefore surprised to find on further examination a completely cleft palate, but I was not prepared for six fingers on each hand, which was the next deformity I noticed. The umbilical cord, too, presented unusual conditions, having portions of Wharton's jelly partially detached and hanging from the main mass of the cord very much as the appendices epiploicæ hang from the large intestine, some of the masses, however, being pedunculated and some sessile.

While I was carefully examining this condition of the cord I detected another abnormality in the shape of a circular red mass of a finely granular appearance, having a central depression with a surrounding prominent margin, situated about half an inch from the margin of skin at the

umbilicus, along the cord. The depression admitted an ordinary probe with ease, and the probe passed for a distance of $1\frac{1}{2}$ inches without any difficulty. Soon after birth a small quantity of a dark green material, evidently meconium, oozed from this opening.

My next step was to examine the anus which in external appearances was normal. The probe passed easily for $2\frac{1}{2}$ inches up the rectum; accordingly I divided the cord in the usual manner and directed that the stump should be dressed with vaseline of boracic acid on lint, and that the dressing should be kept for me to see, as well as the ordinary napkins used.

The child breathed imperfectly from the first and swallowed with difficulty, and the mother had no milk for it. The parents were very anxious that I should operate upon the hare-lip at once, but I refused to do so, and the child died on the third day. In the interval, considerable quantities of meconium passed both by the opening in the cord and by the natural anus.

A post-mortem examination was obtained with much difficulty, and, to my great regret, I was unable to obtain possession of the whole specimen. I succeeded, however, in removing the small portion which is before you to-night, and which will show quite sufficiently the most important of the many deformities present in the case. It will be noticed, first, that the intestine connected with the abnormal opening is *small* intestine. I was careful to notice that it was the proximal part—if I may use the term—which was of larger size than the distal.

The *second* case which is before you in a complete specimen, is another instance of multiple deformity, and some points about it are of the greatest possible interest. There is, as will be at once noticed, a very large spina bifida, the limbs are very curiously displaced. There is a complete absence of the umbilical cord and the limbs as a separate isolated structure; the pelvis is incomplete, and the abdominal wall is incomplete, so that some of the viscera—liver, intestines, &c.—are not completely included in the abdominal cavity, and the placenta apparently arises directly from the abdomen. The vessels of the placenta form a prominent ridge at the edge of the mass. Last, but by no means least in importance, is the complete absence of any external organs of generation, unless, indeed, the very small papilla in the right side of what answers for a perineum be taken as a rudimentary scrotum or labium.

I have refrained from making a dissection of the specimen, because I intended to present it to the Museum of the University, and wished it therefore, to be as complete as possible; it has, however, been torn in handling the thin mem-

brane covering the mass of protruding viscera and connecting the body with the placenta. So far as I have been able to ascertain without further dissection, there is no anus or urethra.

These two cases are specimens of conditions which are, I believe, of very rare occurrence, especially the first case. The only recorded instances of openings at the umbilicus communicating with the intestine, which I have been able to trace, are two in number: of these, one was under the care of Timothy Holmes, but in it the fistula was not discovered until 14 days after birth. There was in that case a bifurcation of the funis, and in the left half a hernial projection of a coil of intestine, and it seems highly probable that the fistula resulted from sloughing after ligature of the funis and contained intestine.

The other case is recorded in the Pathological Society's Transactions, vol. VII., p. 216, but the description is obscure and the exact condition of things doubtful. It is only right to state that, through want of opportunity, I have not consulted the works of any foreign authors, probably some reference to a similar condition would be found in the writings of St. Hilaire or Bischoff on Teratology.

The *ætiology* of congenital malformations is a study of much interest. In olden times, and indeed quite modern times also, they were the subject of superstitious beliefs and incredible absurdities; their occurrence was looked upon as a presage of ill-fortune, a proof of divine vengeance, the effect of witchcraft, the result of intercourse with lower animals or with demons, or with women during menstruation or pregnancy. In modern times even, it has been seriously suggested by Demeaux, that copulation during a state of drunkenness may engender malformations, but such a suggestion is unsupported by any valid evidence, and now-a-days, when so much of the history of intra-uterine developmental processes is well-known, we need not draw upon our imagination for explanations of their occurrence.

That much superstition still lingers in the minds of the laity in connection with congenital malformations we must all know by experience, but we are too apt, I believe, to reject at once any suggestion of the influence in the production of abnormalities exercised by maternal impressions during pregnancy. The effect of prolonged or sudden intense emotion on physiological processes in other departments of the human organism (and especially in secretory processes) is well-known and well-established; may not, then, similar causes have like results in modifying and altering the nutrition and development of the embryo in utero?

However this may be, it cannot be doubted that *causes* of a general nature affecting the

parents have powerful influence in the production of malformations, and of these causes, *syphilis* and *chronic alcoholism* are especially potent; while, where already developed, the malformations themselves are especially susceptible of *transmission through several generations*, and even of *exaggeration by transmission*. We are probably, all of us, acquainted with cases of supernumerary digits occurring in more than one generation of the same family. In a case on which I operated recently for supernumerary toes, a similar condition with the hand had been present in the maternal grandfather; a maternal uncle also was born with supernumerary toes, while the mother of my patient herself had a bud projecting from the distal extremity of the 5th left metacarpal bone.

The exception proves the rule, and it is interesting to notice here that in neither of the cases which are the subject of this paper was there any traceable tendency to malformation by heredity.

The list of causes of these malformations would not be complete without some notice of *physical* and *mechanical* influences acting upon single individuals, and of the *effects of pathological processes* in the foetus itself or its appendages. It was shown, experimentally, by Panum and Dareste, that different degrees of heat and mechanical shocks, always lead to some malformation; some of the cases were obviously due to lesions of the amnion or placenta, or to twisting of the funis round the foetus (intra-uterine amputation of limbs, &c.), while inflammatory processes in the foetus and its appendages undoubtedly produce morbid adhesions and serous effusions, which by interfering with nutrition lead to arrest or alteration of the developmental processes.

And, *lastly*, it must be noted that, as in after life, so in the embryo, a primary lesion often induces a secondary one—as, for example, when a lesion of the nervous system, such as is often involved in the condition of spina bifida is associated with the malformation known as “club foot” as cause and effect.

Many classifications of malformation both congenital and acquired, have been suggested—I need not trouble you with them. The best is that of Curnow, who arranges them with an *Ascending series* and a *Descending series*, the former including conditions from supernumerary digits to cases of double and even treble monsters; the latter including conditions from a mere default of a digit or organ, to the monster of almost shapeless mass, “sans eyes, sans nose, sans teeth, sans everything.”

To the former class must be added as a sub-heading, the so-called *Parasitic monsters*, characterised by a more or less rudimentary individual,

being implanted upon and growing at the expense of another which is more or less fully formed. This sub-class includes a large range of varieties, from the case in which a complete parasite has been found implanted in the abdominal cavity of its host, to those tumours commonly known as congenital cysts, in which bones, teeth, hair, etc., are found.

It is not my intention to enter here into the consideration of the first class in detail, except to note that the method of production of the ordinary multiple monster was not at all understood until the late Dr. Allen Thomson showed that in birds at least) more than one “primitive groove” may be formed in the same area germinativa. A little consideration of the result in the course of development of such a condition, makes it easy to see how double and even treble monsters must be formed. The points of junction of the trunks in these cases being determined by the point at which the double or treble groove in the blastodermic layer of the early embryo were fused from the first.

In the second class—viz., that of malformation by deficiency or arrest of development—the “Descending series” of Curnow—we have many familiar instances, and when we consider how, for instance, the bones of the face develop by the union from behind forwards of two bilaterally symmetrical halves, as is well seen in the vomer, we have an easy explanation of the formation of hare-lip and cleft palate. In the conditions known as hypo-epispadias we have instances of the arrest of similar processes, and these are of special interest because there is a special factor at work in their production, viz., that which I may call the sexual intention in the development of the embryo and the failure of that intention to guide aright the developmental processes and to bring them safely to their before-known and determined conclusion: cases where nature, whose intentions are usually so fixed and whose determination so unalterable, becomes, apparently, confused, so that neither one or other process is correctly fulfilled.

Limit of space only, prevents the multiplication of instances of malformation belonging to this class; let us look for a few moments at the cases which are the subject of this paper, in their relation to the developmental changes which have resulted in their production.

In the first case, the malformation at the umbilicus is the most important of the many present in that unfortunate specimen of humanity. The condition in which there is a hernial protrusion of a coil of intestine into the cord—a stage of arrested development only one degree less than that which we are considering, and is by no means of rare occurrence, but this condition is very

uncommon. We shall all of us remember how in the processes of development, an infolding of the hypoblast produces the three portions of primitive gut known as fore, hind, and mid gut respectively, how that the mid-gut communicates freely with the umbilical vesicle, the general yolk-sac, at first directly, but later on by the constricted vitello-intestinal duct, and is much later in its completion than the fore and hind portions; how that the umbilical vesicle and its duct to the intestine gradually diminish in size and can only be detected at birth by careful examination—the former, as a small sac, lying under the amniotic covering of the placenta, and the latter as one of the constituents of the cord; how that the mid-gut is completed by the infolding of the hypoblast, with some additions of mesoblastic elements, so forming what ultimately becomes the small, and the main mass of the large, intestines; and how that a coil of ileum remains in the umbilical cord until about the 12th week of foetal life, when it is withdrawn into the abdominal cavity. But even so, we are without an explanation of how the *opening* in the case before us was formed. Not only has there been absorption of the wall of the intestine itself and all its layers, but also of the foetal membrane covering and surrounding the cord, and so the formation of a direct communication between the intestine of the foetus and the cavity of its amnion, involving, unless other circumstances continued to prevent it, a free passage on the one hand for amniotic fluid into the intestine, and, on the other hand, for the contents of the intestine into the sac of the amnion; in other words, the amnion which is normally a closed sac is here incomplete.

I should note here that there was not any particular distension of the intestines with fluid, nor was there any special discolouration of the liquor amnii, so far as I could see during its rapid escape.

The *second* case acquires special interest when taken with the *first*, for here we have, in respect of the malformation of the abdominal wall, a stage of arrest of development very much earlier than in the first case. The process of infolding of epiblastic and mesoblastic layers which takes place concomitantly with the completion of intestine as described above, has here ceased at an early date, and a larger mass remains external to the foetus—a cyst containing parts of the abdominal viscera.

This malformation is, however, not by any means so rare as one of the other conditions present in the specimen—I refer to the absence of external genitals; but without a careful examination of the internal parts I refrain from any detailed consideration of this condition.

A few words on the surgery of the first case. Had the child lived, the removal of the supernumerary digits and the rectification of the cleft condition of the palate and lips would have been simple enough. The condition of things at the umbilicus would have presented greater difficulty, for, as you will observe, the bowel beyond the opening is attenuated and the bend in the intestine is very sharp, so that a plastic operation without removal of the “spur” would almost certainly have failed. I should have been disposed to use Dupuytren's Enterotome in the first instance, as recommended by Mr. Holmes for adoption in any case similar to the one under his care.

In conclusion, gentlemen, we cannot study nature too closely, not only in her normal processes, but in these instances such as these before us, where she departs from her usual beaten tracks. The study of embryology which has received so great a stimulus during this century, and especially during that portion of the latter half of it which has already passed over our heads, has done more than all to enlighten us in her ways, and to free our minds—and through us, the minds of those who must be guided by us—of superstitious and erroneous notions, and to bring us nearer to that perfect knowledge towards which all our efforts tend, and which can only be built upon the sure and safe foundation of observation and inductive reasoning.

ON THE TREATMENT OF MALIGNANT DISEASE OF THE TONGUE.

READ BEFORE THE N.S.W. BRANCH B.M.A.

By R. SCOT SKIRVING, M.B., ASSISTANT PHYSICIAN TO THE PRINCE ALFRED HOSPITAL, SYDNEY.

(Continued from page 86.)

With regard to the use of the thermo-cautery, I would remark that in partial excision it is doubtless often found very useful, but in total excision there is but little room to use it satisfactorily without enlarging the cavity of the mouth.

I shall refer more fully to the advantages and disadvantages of the system of burning when I have finished what I have to say regarding the galvano-caustic ecraseur I will, however, refer

to one possible objection to it, viz., in all tongue operations, of course, chloroform is to be preferred to ether, as the free admixture of air, the inhaler being some distance from the mouth, is an advantage not only to the patient but allows the operator to work. Still, should it for any reason be advisable to use ether, it would be inadmissible in a burning operation, for fear of an explosion.

I next must ask you to consider briefly the merits of removal by the simple ecraseur. Removal of the whole tongue can be effected by this means by a simple intra-buccal operation. To gain room, as before mentioned, Mr. Collis and others have slit the cheek. In cases of entire removal of an extensively diseased tongue, considerable difficulty has been found, and the oblique section so made is also a disadvantage. To obviate these defects straight needles have been passed through the tongue, to keep the wire in position during the earlier turns of the screw, and Sir James Paget has advised the free separation of the sub-lingual tissues, in order that, among other advantages, the metal end of the ecraseur might be placed well back. Nunneley, of Leeds, made a small sub-mental opening and passed the wire of the ecraseur through it round the tongue, through which pins had previously been passed, notwithstanding which it was still found that the section so made was often oblique. The dependant drainage opening was, however, an advantage. Mr. Barwell has again slightly modified this procedure by passing, in a manner which it is needless to describe fully, the chain or wire of the ecraseur through a sub-mental opening into the mouth, very fully back, a little beyond the last molar tooth, near the jaw, by which means the lingual branch of the fifth nerve is included in the loop and divided, and a so-called "painless" operation effected. After the section of the posterior part of the tongue is completed, the loop of the wire is passed forwards over the front of the tongue, and the remaining anterior sub-lingual tissues are divided. As regards completeness of removal this method is satisfactory. Moreover, it leaves little or no disfigurement, and if done slowly there should be no hæmorrhage. Mr. Barwell calls it a painless operation. Well, if the patient be under the influence of an anæsthetic, painlessness does not come in as a factor to be considered at the time of the operation, and as to its leaving a specially painless stump because of the co-existent neurotomy, I would point out that this is not peculiar to this operation. As to his leaving the anterior attachments of the tongue to be divided last, I question if Paget's plan of separating them first be not the most convenient course, if, for

this reason alone, that should bleeding occur on the completion of the section of the tongue, that organ still being in situ, would very much interfere with the rapid and easy application of a ligature to the bleeding point. Still, we must admit that the important factor of a vertical section placed well back is amply attained by this method.

Excision by means of the galvano-caustic wire is the last of the methods I will speak of this evening. It has been extensively used in England at the Brompton Cancer Hospital, and with marked success, judging from the report upon it by Dr. Purcell, in the *Lancet* of July 5th, 1879. In the method of application used at the institution referred to, a submental incision is made (after Nunneley) and an opening made into the mouth in front of the frænum. The canula of Middeldorph's apparatus is inserted and the wire passed round the tongue. Without entering into the various manœuvres necessary, it is sufficient to say that the wire being tightened, the canulæ are attached to the body of the handle, the circuit is next completed, and the wire being slowly screwed home, the tongue is gradually burnt through in about seven to twelve minutes.

Bleeding, Dr. Purcell contends, only occurs when the wire has been too greatly heated, or has been too rapidly screwed home. He also points out that the steps of the operation can be gone through methodically and slowly, and alludes to the absence of tearing or dragging on contiguous structures. I need scarcely add that the use of this apparatus can be applied to entirely intra-buccal plans of operation and likewise to the concluding stages of Syme or Rignoli's methods. A more complete removal by this means might, I think, be effected by passing the wire far back, as suggested by Barwell, after a previous clearance of the anterior sub-lingual attachments. This, at least, would give you a vertical section.

In comparing the simple and galvanic ecraseur much may be said in favour of both. With reference to the simple instrument, it has seemed to me, from examination microscopically of the posterior surface of the part of the tongue removed by this means, that, in spite of all care, the wire too often slips forward, and in many cases the section is finally effected at a point dangerously near, or actually up to, the seat of the disease. This objection, at any rate, holds true in purely intra-buccal removals. As regards hæmorrhage at the operation, it seems to occur pretty frequently, and occasionally we are troubled with secondary oozing. In using the galvano-caustic wire, hæmorrhage is rare at the time of the operation, if the section be performed slowly, and the wire be kept at a moderate temperature, but

it pretty often occurs secondarily during the time of the separation of the sloughs, caused by its cauterising action. But we must in one sense consider the sloughing as an advantage, as it destroys a still wider margin of possibly infiltrated tissue. Lastly, the expense and difficulty of keeping in working order the galvanic apparatus is doubtless an objection to its coming into very extensive use.

I shall now make a few general remarks on the respective merits of cutting, crushing, or burning, into which divisions all the above-mentioned methods practically resolve themselves. Mr. Whitehead, as might be expected, is strongly in favour of a cutting operation, and with the results of his operations, and certain suggestive remarks which he makes, and to which I shall shortly refer, there is no doubt weighty evidence in favour of his opinions. He objects to crushing, on the ground that it frequently fails to do what it is intended to do, in cases where the tissues are friable, cutting through without any special action, and if firm, the wire breaks, or hæmorrhage occurs. As to a burning operation, he dislikes the difficulties of application and considers that the risks to life are materially augmented by the chances of secondary hæmorrhage and septicæmia. Professor Stokes states an exactly contrary opinion, namely, that "he had noted that removal of the organ by a cutting operation is not only liable to be followed by hæmorrhage, but also, what is of more serious moment, by septic infection." Mr. Whitehead, judging from a return of 250 cases, as yet, so far as I know, unpublished, concludes exactly the reverse. I may add, that in all the cases which have come under my observation which terminated fatally with septic symptoms, a crushing or burning operation had been performed. Mr. Whitehead does not believe that the use of the simple *ecraseur* avoids bleeding at the time because of a crushing of the arteries; he thinks that the immunity to hæmorrhage is simply due to pressure, and such being his belief, he adds, how much less likely are the lymphatic channels to be so occluded by crushing, the construction of the *ecraseur* being opposed to such an inference. The bearing of these remarks is evident when we consider the subject of septicæmia; with a slough attached to healthy tissue, be that slough the result of crushing or burning, there must be in all probability more risk of septicæmia from auto-infection than in the case of a clean cut wound, which in ordinary conditions must receive infective material mainly from the outside world.

Take the example of the puerperal state. Are not the retention of coagula, membranes, or portions of placenta, in the uterine cavity allowed

on all hands to be one of the chief causes of septicæmia after labour. How often have we not seen the temperature fall and the pulse diminish in frequency after a thoroughly satisfactory performance of uterine syringing. Mr. Whitehead may perhaps be a little one-sided in his advocacy of a cutting operation, yet his remarks are important and suggestive and well worthy of attention. I hope at some future time to examine microscopically the state of the tissues at the point of section after crushing or burning operations, with a view to satisfy myself as to the real mechanism, whereby hæmorrhage is prevented in crushing operation, and also with a view of ascertaining, from the state of the parts, what special liability there may be to septic absorption. It lately occurred to me that it is possible that an occlusion of blood-vessels and lymphatics, with a corresponding prevention of immediate or secondary hæmorrhage, and risk of septicæmia, might, with the formation of only a very small slough, be effected, by using a powerful clamp-like instrument, whose roughened blades could by pressure be forced in contact, and so remove the organ. I thought of this some time ago, and on looking up the literature of the subject I was surprised to find that a somewhat similar suggestion had been made by that most indefatigable worker in this department of surgery, I refer to Mr. Whitehead.

It now remains for me to state to you the conclusions to which a study of this subject has led me, and these, briefly, are as follows:—

I. That the specific treatment of malignant disease has yet to be discovered.

II. That a palliative measure, such as division of the lingual nerve, is a valuable means of diminishing salivation and relieving pain, in cases where radical operative treatment is inadmissible. That ligature of the lingual arteries temporarily retards the growth of the neoplasm, and is indicated to restrain otherwise uncontrollable hæmorrhage from an ulcerated surface, while in cases where a special liability to bleeding exists, where the patient has no blood to spare, where assistants are few and unreliable, and finally, when the patient subsequent to operation cannot be kept under immediate supervision, a deligation of one or both arteries may be a wise proceeding as a preliminary to further more extensive operative treatment.

III. That, in our present knowledge of the subject, it is impossible to say that any one form of operative procedure is the best; that each case and its peculiarities must be judged of, as regards operative interference, on its own merits.

IV. That without doubt the entire tongue can be removed down to the epiglottis by a strictly

intra-buccal operation; that if the disease be really limited to that organ, and if assistants are to be relied on, Mr. Whitehead's method seems to show that the danger of hæmorrhage at the operation is in the majority of cases too much dreaded, and that subsequent troubles, such as secondary hæmorrhage and septicæmia, are infrequent after a cutting operation such as his. In view of the possibility of blood passing down and forming a coagulum in the glottis, it is a wise precaution to have a tracheotomy tube ready in case a sudden laryngotomy should become necessary during the performance of the operation.

V. That if there be special dread of bleeding during the removal of the tongue, if assistance is not of a satisfactory character, and if the apparatus necessary can be relied upon, then a slow removal by the simple, or galvano-caustic ecraseur, the latter preferably, is, notwithstanding the objections to it of secondary hæmorrhage or septicæmia, a wise and satisfactory procedure, especially if the chain or wire be passed submentally, after the manner of Barwell, the anterior lingual connections being first severed, as advised by Sir James Paget. Lastly, the submental opening can be utilized to drain through.

VI. That if more than the tongue be involved in the disease, as, for example, the floor of the mouth, gum-textures, or fancial pillars, then, if any operation be undertaken, it should be that in which the inferior maxilla is divided, the concluding steps of such operation being effected by cutting, crushing, or burning.

VII., and lastly. That the sub-maxillary glands, if enlarged, are of necessity no bar to operation, but may be removed by external incisions; it may be, the lingual arteries might at the same time be tied, the tongue removed, and the lateral incisions used for drainage purposes.

This concludes what I had to say on the subject. I trust I may not be considered presumptuous in having taken such an ambitious topic, one in which no one realises more fully than I do that a long lifetime of experience is the best prelude to forming conclusions. I must plead in excuse the interest I have ever felt in the subject, and the uncertainty, the want of "reason for the faith that is in them," if I may be pardoned so putting it, which one sometimes notices on the part of the givers, where an opinion has been sought as to the kind of operative procedure to be adopted in certain cases of lingual disease. I have, therefore, been led to enter somewhat fully into the subject, in the hope that by provoking individual expression of opinion we may be helped, each and all, to more definite views—in short, that in the multitude of counsellors there may be found wisdom.

VACCINIA AND VARIOLA IN THE SAME PATIENT AND AT THE SAME TIME.

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IN February, 1868, I was doing Assistant House Physician's work at K. C. H., and saw numerous cases of variola among the out-patients. Many of these were among the vaccinated, and the disease was of the mild type usually seen among those protected by vaccination; some running a normal, but very mild course, others aborting, and causing so little inconvenience as not to necessitate a home confinement to bed. One day a man, R. P., aged 27, presented himself, stating that he was living in a house where there had been three cases of small pox, and, as he was unvaccinated, he asked for advice on the subject. Of course I vaccinated him immediately, and in four places on each arm, telling him to come and see me every day if he could. The very next day he came complaining of pain in his back and head, and as the thermometer showed a temperature of 102.6, I thought we had all the material for a very interesting case. Variola and vaccinia contemporaneously in the same individual! Surely enough our most sanguine anticipations were realised. I told the man to go home and to bed, and I would attend him at his own house. I need not enter into all the details; the vaccination was successful in every place, eight well-developed Jennerian vesicles appearing, four on each arm. The temperature declined after the second day of observation, when it reached 103 deg., and the variolous rash began to show itself—forty-three umbilicated pustules appearing on different parts of the body: three on the face, eleven on the chest, seventeen on the back, and the remainder on the legs. The disease ran a perfectly normal, but very mild course; the patient strongly objecting to being confined to his bed after the first two days. Now, did this case show in a wonderful manner the protective power of vaccinia, or did it not? Everything at first pointed to a decidedly severe attack, and a very mild one ensued. However, whatever doubt may exist on this portion of the case, none can exist on what follows. Taking two intelligent clinical clerks (one since dead, a martyr to his sense of duty) into my confidence, on the eighth day I most carefully took some perfectly clear lymph from the Jennerian vesicles, and determined to perform a crucial experiment as to the power of any other disease but vaccinia being communicated with the clear lymph of a Jennerian vesicle. All three of us had been recently revaccinated, so we did not consider ourselves fit subjects for experi-

ment, but, in fear and trembling, I vaccinated a healthy child of eight months old, and to my delight vaccinia, and vaccinia only, was developed, and ran a perfectly normal course. We then vaccinated thirteen others, eleven of which were successful; the remaining two "did not take." Is any better proof required of the well-known, but occasionally contradicted fact, that vaccination carefully performed will result in nothing but vaccinia?

REPORT OF TWO CASES OF FRACTURE OF THE SKULL.

READ BEFORE THE MEDICAL SECTION OF THE ROYAL
SOCIETY OF N.S.W.

By C. W. MORGAN, M.D., SURGEON TO THE
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CASE NO. 1.—FRACTURE OF THE LEFT SIDE OF CRANIUM FROM RIDING VIOLENTLY AGAINST A TREE.

The following case is interesting, as affording an instance of the enormous extent of injury the cranium and brain may sustain without immediate loss of life; and the history will show that, in addition to the severity of the fracture and consequent shock from which speedy collapse might have been expected, the unfortunate sufferer, at the time when his condition required absolute rest and the most careful attendance, was subjected to so continued a succession of misadventures and hardships, that his physical endurance and tenacity of life are little less than marvellous.

C. L., *et* 32, bushman, living at Port Stephens, left the "Tea Gardens," a publichouse on the southern shores of Port Stephens harbour, at 1 o'clock on Tuesday, 28th October last, on horseback, being then under the influence of drink. He rode away towards his home at a rapid pace, and about three hours later he was found on the roadside, lying insensible at the foot of an ironbark tree, which bore evidence of his having ridden violently against it, by a large knob having been torn off the tree, and by the bark being blood-stained, and having human hairs entangled in its fibres. His horse was feeding near at hand, so the insensible man was placed on it, and taken back to the little wayside inn, whence he had started, a distance of seven miles.

It was thought best to take him at once to the hospital at Newcastle, and the local police constable took charge of him. Still unconscious, he

was placed at the bottom of a boat and rowed down the harbour to Nelson's Bay (a small settlement, and lighthouse station, about two miles from Port Stephens Heads, and nine miles from the "Tea Gardens.") Here a small steamer was lying, by which they hoped to get to Newcastle, thirty miles away. On arrival there was some delay, as the night was advanced, and a strong southerly gale was blowing: the steamer, however, got up steam and proceeded to sea. After knocking about all night and making no headway against the wind, the little steam vessel was compelled to return to harbour, and arrived at her moorings at Nelson's Bay on the morning of Wednesday. The patient was transhipped to the boat again, and conveyed back to the "Tea Gardens," reaching that locality about midday. It was then decided to send for a doctor, and a gentleman, whose name I have not been able to ascertain came, I believe, from Stroud. All this time the patient had remained insensible, but I am told that he was able to swallow what was poured down his throat. He had travelled since his accident, by horse, boat, and steamer, a distance of between 50 and 60 miles, subjected to constant shaking; the danger of frequent removals, and the wet and cold inseparable from tempestuous weather at sea. It was next resolved to send him to Newcastle by land, a distance of about 85 miles, and he was then taken by the police constable and some other person in a dray to Stockton (Newcastle, North Shore.) This journey took all Thursday and the best part of Friday, on the evening of which day he was received at the hospital at about 7 o'clock 77 hours after his accident, having travelled about ninety miles, more or less. The incidents connected with the treatment of the patient during this remarkable journey I have not been able to collect, as the constable returned to his district without my having had an opportunity of seeing him; but I believe the patient was nourished by pouring small quantities of milk, brandy and water down his throat at intervals.

I first saw C. L. half an hour after his admission to the Newcastle Hospital. He had been placed in a bed and lay on his back; he was in a state of complete hemiplegia; the right side being powerless—his bladder, however, was empty, and he had not lost the power of micturition. He was quite unconscious; the face drawn to the right side and twitching; the eyes rolling restlessly and squinting inwards; he seemed on the verge of an epileptic fit. The left side of his head and face was tumid and swollen, but there was no wound; blood issued freely from the ear, and there was every evidence of a fracture of the base of the skull. The patient

and two other boys were shooting near Hexham, on the banks of the Hunter River. Patient carried evidently felt pain when the injured part of his head was handled, and put up his left hand and grasped my wrist so firmly that I had to unclasp his fingers, and have his hand held by an attendant while I shaved his head, and examined the injury. I discovered a line of fracture on the left parietal bone, just above the insertion of the temporal muscle, but the parts were so swollen that it was difficult to be certain of the extent or character of the depression. No further time was lost; a hurried consultation of my colleagues, Drs. John Harris and Ashe, was arranged for 9 o'clock, at which time it was decided to explore; accordingly I made a free incision over the temporal ridge and exposed the skull; there then appeared a depressed fracture, extending further in every direction than could be traced, but having selected a spot which appeared most suitable, I applied a small trephine and removed a section of bone at the edge of the depression, and further, without using force, removed another loose piece of bone, thus exposing the dura mater. There was no apparent injury to this membrane, and I found but a small clot, which I removed with a scoop; I then elevated as much of the depressed bone as I could (indeed, all that appeared to be making pressure) and closed the wound, having left a fine piece of drainage tubing. The result was very marked; the patient losing the twitching of the facial muscles, and the squint and rolling of the eyes subsiding. The pulse became softer and less frequent, and the patient sank into a quiet sleep. On the following morning his condition was very satisfactory; the pupils were fairly obedient to light; the eyes followed the movements of those in attendance on him, seeming to have some expression. He swallowed eagerly the nourishment given him, even raising his left hand to the feeding cup in his anxiety to take the food it contained. The present being the fifth case in which it has been my duty to trephine, I was not too sanguine of a favorable result by the partial subsidence of evidences of cerebral irritation, as I have always found abscess to follow a depressed fracture, unless the pressure has been relieved by elevation before thirty hours after its occurrence—even although the dura mater has apparently received no injury. The present case proved no exception, and, after lingering until the evening of the 3rd November, the patient became quite comatose, and died the following morning, being the seventh day after his accident.

Post mortem, six hours after death, in the presence of Drs. Ashe and Beeston. Large patches of ecchymosis over left side and top of scalp; subjacent pericranium very much thickened, infiltrated and of a dark chocolate colour. On

removing the thickened pericranium, the extent of the upper lines of fracture could be perceived. The whole of the left temporal bone, and the lower margin of the left parietal bone were smashed to fragments, like an eggshell, and only held together by their pericranium. A long fracture, measuring nearly 7 inches, extended across the frontal bone, through the anterior angle of the right parietal bone, until it was lost on the squamous portion of the temporal bone of the same side; when the calvarium was sawn off, this long fragment fell off therefrom, as did the portions of the parietal, temporal and frontal bones included in the comminuted fracture of the side of the head.

The dura mater was disorganised, thickened, infiltrated, and covered by a thin stratum of clot. There was a rent in the dura mater along a considerable part of the extent of the long fracture above described. Beneath the dura mater were tracks of clot, corresponding with the general outline of the fractures described. The vessels of the brain were engorged, and a large abscess had formed in the middle lobe on the left side. The substance of the brain was greatly disorganised and any exact examination of its centres was impossible. Having removed the brain, the exact extent of the lower fractures were ascertained. The squamous portion of the temporal bone was in small fragments; the petrous portion was broken across, and the internal ear destroyed; a fracture extended backwards towards the basilar process of the occipital bone, and another forwards, dividing and being lost on the greater wing of the sphenoid bone, in one direction, and dividing the zygomatic process of the malar bone on the other. The cerebellum had apparently sustained no material injury, and, doubtless, to this fact alone may be attributed the maintenance of life for so long a time.

The calvarium, which accompanies this paper, will give the Section an idea of the extent of the fractures; some of the larger fragments have been fastened on with cement. I was unable to procure the remainder of the skull, as an inquest was held on the body, which was taken away for interment at a distance.

CASE No. 2.—FRACTURE OF THE SKULL FROM A GUNSHOT.

H. P., *æt* 14, apprentice, was admitted to the Newcastle Hospital on the evening of November 10th, suffering from a severe gunshot wound at the back of the neck, at its junction with the head. It is necessary that I should be a little prolix in my relation of the circumstances of the accident, inasmuch as the medico-legal question of the wound being self-inflicted or otherwise is to be considered. The history was as follows:—About 12 o'clock on the morning of the same day, patient

an old double-barrelled muzzle-loader, charged with No. 4 shot, and had discharged one barrel at a bird, which he wounded. Springing eagerly forward to secure his game, he threw the gun, having one barrel still loaded, over his right shoulder, holding it by the muzzle, and allowing the stock to trail behind him; immediately afterwards the other boys saw the gun strike against the stem of a tree; the gun exploded, and the boy fell. The charge must have gone off at close quarters, striking the lad on the right side of the neck, and proceeding in a transverse direction upwards and to the left, and caused the injury which I shall presently describe. The patient was taken to a house in the neighbourhood—a surgeon was fetched from Raymond Terrace, a distance of about seven miles, and by his directions, the boy was brought by the afternoon train to Newcastle, and admitted to the Hospital at about half-past 6 o'clock, when I saw him on his arrival. He was considerably exhausted, and had lost a good deal of blood, but was quite conscious and sensible. There was a gaping wound at the back of the neck five and a half inches long by about four inches wide, and exposing a portion of the ligaments of the upper cervical vertebra; the muscles were greatly mangled, the skin was torn, jagged and blackened by powder, and the hair was burned and charred. No shot were discoverable, it being evident that after inflicting the wound, the charge had passed away from the body *en masse*. I was able to feel the back of the skull, and could detect some roughness, but no loose pieces of bone. The wound was carefully douched, and its edges brought together with silver sutures, and a pad and bandage applied. There was no loss of power of limbs, no cerebral symptoms, and the boy was given a chloral draught, and ordered saline medicines, &c.

Tuesday, 11th November.—Boy has been restless during night, and could not be restrained from tearing off the bandages; very unmanageable and violent; tosses about incessantly, and rolls from side to side, pulse 120, temp. 102; complains of pains in back of head, but is perfectly conscious, though confused and inclined to ramble in his talk. It was impossible to keep his hands from his head; he strikes the nurses when they attempt to restrain him, and uses abusive language after the manner of boys of his class. His hands have to be muffled and confined by bandages. Takes some fluid nourishment, but finds great difficulty in swallowing; ordered bromide of potassium, with small doses of chloral hydrate.

Tuesday night, 10 o'clock.—Patient still in the same restless state; complains of head; is very refractory, and kicks and strikes those near him. To continue the chloral and bromides. Temperature still about 102; pulse rapid and hard.

Wednesday morning, 2 a.m.—Night nurse reports that the patient gave a scream at this hour, and that his back was slightly arched for a time, and his breathing hurried and strident.

Wednesday, 10 o'clock a.m.—At my visit find boy has not slept at all; very exhausted, but still kicking and tossing; manages to get his bandages loose, his mufflers off, and to tear at his wound. Has great difficulty in swallowing—the jaws inclined to be stiff—threatening of trismus.

Same day, 5.30 p.m.—Dressed the head—wound looking healthy; discharge inconsiderable. Boy objects to the process, and resents the smell of carbolic acid, requesting the nurse to “take away her stinking hands,” and expresses an intention of “kicking her (and all concerned) in the jaw”—ordered 20 grs. chloral per rectum—this was given at 7 o'clock.

At 9 o'clock p.m., the nurse sitting by the patient reports that at this hour the boy, who had been somewhat quieter for a short time, probably from the action of the chloral, suddenly screamed and became moribund. I was sent for, and as my house is within a stone's throw of the hospital, I was able to be at his bedside almost immediately, before life became extinct. There was evidence of violent spasm of the diaphragm, which was thrown upwards; the heart could not be said to beat, it fluttered, conveying a feeling of quivering, or vibration, to the hand; the respiration had ceased, as if suddenly arrested, and the body was slightly arched forward.

Post mortem, 14 hours after death.—On enlarging the wound, and reflecting the scalp, I found that a considerable fracture of the occipital bone had been caused by the concussion of the discharge of the gun. There was no appearance of any shot wound of the pericranium; the fracture was situated just above the insertion of the *ligamentum nuchæ*, and was comminuted; there were several fragments, about six or seven, one of which was loose, but had not wounded the *dura mater* underneath. From one angle of the fractured tract, a long crack extended across the side of the head, about six inches in length; it passed through the parietal bone of the left side, reaching as far as the temporal fossa; a second crack passed upwards, being lost on the upper margin of the occipital bone. There was some little clot under the comminuted fracture, and on opening the *dura mater* of the spinal cord between the skull and atlas, a pent-up clot escaped, which must have made pressure on the spinal cord. I think there can be no doubt that the irritation caused by the fractures I have described, was conveyed to the pneumo-gastric nerve, and resulted in the spasm of the diaphragm, and collapse of the heart, with arrest of the mechanical power of respiration.

NOTES OF EIGHT CASES OF SMALL POX TREATED AT THE SANATORIUM, NEAR MELBOURNE.

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DURING the months of October, November, and December last, the writer was the Medical Officer in charge of the Sanatorium, near Melbourne, and during this time the eight cases forming the basis of the following paper were under treatment. The notes of the cases have been tabulated and condensed in order to make reference and comparison the more easy.

It will be seen that nearly all the cases have been modified by vaccination. The effect so produced varied somewhat; in some, the duration of the disease was shortened, the eruption, however, passing through all its phases, whilst in others the disease was checked when it had reached a certain stage, part of the eruption becoming then abortive.

All the cases now brought forward can be traced to their origin; in some, the exact date of exposure can be determined, and the attack can thus be followed throughout.

From the beginning of October to the early part of December about three hundred persons, all of whom either came in contact with those affected with small pox, or associated with those that did, were vaccinated. This number does not, however, represent the total number so exposed. This cannot be determined; and here it may be mentioned, that a cabman who, though taken ill on a Wednesday, continued driving his cab till the Saturday evening following, yet the disease was not conveyed through him to one single person, and other similar cases could be found.

Quarantine regulations in Victoria are not so rigidly carried out as in New South Wales, where it is the custom to detain at the Quarantine

Station all those who are known to have come in contact with the different patients. In Victoria, quarantine is limited to those living in the same house as the patients, and these are confined in the house, whilst all those known to have come in contact with the patients are vaccinated, but not detained.

Vaccination, however, being compulsory in Victoria, and a proportion of the population being also re-vaccinated, has without doubt prevented the disease from spreading as it would otherwise have done.

In a certain number of cases vaccination does not take, and doubt thus exists as to what security, if any, these persons have against an attack. In two of the cases under review, vaccination had been performed several times, and yet the persons suffered from the disease.

The time of exposure cannot be determined in four of the cases. In two of the remaining patients the symptoms appeared on the tenth day after exposure, and in one on the ninth day. In the last case a child five months old, and at the breast, the symptoms, as far as can be judged, appeared on the eleventh day, about two days after its mother was taken ill.

Excluding A, in whom the disease proved fatal in an early stage, the disease passed through all its phases in five cases, viz., B, C, D, E, and F; in the remaining two, G and H, the eruption was abortive, except on the hands and face.

The condition, as regards vaccination and the severity of the attack, was as follows:

A.—No information could be obtained from or about this patient, and no marks could be found on the arm. He had a violent attack; the eruption was confluent, and from an early stage he exhibited severe mental symptoms. He died in the seventh day after admission.

B was vaccinated in infancy, and there was one mark on the arm; The patient had a severe attack, dessication being prolonged and pitting noticeable on the face, though to a slight extent. He was detained at the Quarantine Station for six weeks.

C had a mild attack. She was vaccinated in infancy, and again ten years ago, when, however, it did not take. Three marks were plainly visible on the arm. In this case there were few symptoms after the eruptions appeared, and she soon became convalescent. The number of spots was small, but all proceeded to scabbing.

D.—This patient had been vaccinated on several different occasions, but without success. It is to be noted that the patient's mother was likewise vaccinated three times unsuccessfully, and not at the same time as her daughter. The attack in this case was a severe one; the eruption was most profuse and distinct, and the case was complicated with ophthalmia which proved very troublesome.

E.—This patient was vaccinated for the first time on the fifth day after exposure, and she was taken ill on the ninth day. The vaccination was successful. The attack was a mild one, and the eruption sparse, most spots appearing on the face and but few on the body.

F.—Infant daughter of the patient E. She is five months old, and at the breast. She was first vaccinated on the fifth day after exposure. So far as can be judged, the symptoms appeared on the eleventh day, two days after they appeared on the mother. The attack was mild and the eruption sparse.

G.—This patient was vaccinated five times in all. The first time was in infancy, and the fourth when she was eighteen years of age. She was again vaccinated, unsuccessfully, on the third day after exposure. No marks could be found of the previous vaccinations. She was taken ill on the tenth day, and the attack was mild. The eruption was abortive except on the face and hands.

H was vaccinated in infancy, and had three marks on the arm. He was again vaccinated, but unsuccessfully, on the fourth day after exposure, and the symptoms appeared on the tenth day. The attack was not severe, and the eruption was abortive except on the face and hands.

A few points connected with the symptoms in the different cases are worthy of a passing notice.

The period of incubation was free from symptoms in all but one case, in which the patient complained of headache the day after she visited the person from whom she contracted the disease. The headache continued till the ordinary symptoms of the disease manifested themselves. Lumbar pain was entirely absent in one case, but here the patient complained of pain in both legs, especially in the knees, which continued till the eruption made its appearance. The symptom was present in all the other cases (excluding F, *aet.* five months) and was particularly severe in B, lasting till the onset of the pustular stage, and associated with general pains throughout the body.

Emesis was present in three cases, one of whom, however, was pregnant. In no case was it severe, and it lasted but for a short time, and called for no treatment.

Constipation was present in every case throughout, except in one case where diarrhoea occurred for six days. This was decreasing on admission, and ceased the third day after without any special treatment, and was followed by constipation.

Excluding F (*aet.* five months) every patient suffered more or less from delirium. It lasted as a rule for about two nights, except in one patient in whom it was severe and persistent. The attack in this case proved fatal on the sixth day after admission.

Swelling of the face, though present in every case to a slight extent was marked in one only. One eye was completely closed, and the other nearly so. It soon disappeared.

Pain in swallowing, though by no means a prominent symptom, was present in the majority of cases, lasting however, but for a short time, and demanding no special treatment.

Roseola, as far as can be gathered, appeared in three cases. In one, its presence could be seen on admission, and it is noteworthy that the attack, though promising to be a severe one, resulted mildly.

The eruption made its first appearance either on the forehead or the wrists, and in one case it appeared on the forehead in the morning and on the wrists in the evening. In every case the

eruption, or part of the eruption, passed through all its stages, variously modified, however, in some.

In two cases, G. and H., the eruption proceeded to the scabbing stage on the face and hands only; on the rest of the body the eruption aborted, some drying up in the papular, others in an early vesicular stage. The scales resulting, soon came away, and the site was marked as though the eruption had passed through all its stages but very superficially.

A few spots, generally not more than three or four, appeared in some of the cases at a late stage of the disease and passed through all the phases.

Great discomfort was produced by the eruption in the palms of the hands and soles of the feet, owing to the hard and almost inelastic tissues in those parts.

This was especially noticeable in the patient H., who could not bear the least pressure and, if touched otherwise than gently, screamed from the pain. This severe pain lasted little more than one day, and then gradually passed away. It may be mentioned that this patient was a cabman, and his hands were very "horny."

Two other patients complained of the pain in these parts, but not to the same extent.

In two of the cases small nodular hyperæmic spots appeared in the site of the eruption after the scabs had fallen off. These were somewhat larger than the head of a large pin. Soon after their appearance a fine scale formed on the surface. This, in a few days, came away, and they began to diminish in size. These were found chiefly on the face.

Pitting occurred in three cases, and in them it was not severe.

The complications in the eight cases under review were few. In one fatal case mental symptoms were early manifested. Delirium was marked for two days before his admission to the Sanatorium. During part of this time he wandered about and, on his admission, he was in a precarious condition. The patient was at times maniacal, and required constant watching. During part of one day the delirium abated to some extent, but in the evening it was as bad as before, and so continued till the patient's death on the sixth day after admission.

Ophthalmia proved very troublesome in one case. The patient had, for a length of time prior to the attack, complained about her eyes—they were weak, and there was constant pain, especially in the right eye. The sensation was described by the patient as a "scraping at the back of the eye." During her illness this pain was greatly increased, and was present to a much less extent in the left than in the right. At the time of her

discharge the pain had left the eyes, but the right cornea was partially opaque, though beginning to clear, but the eye was unable to bear the light. The left one was fairly well.

Suppression of breast milk took place in one patient whose child was five months old, but the milk returned in six days. At this time the eruption had spread over the body, and was becoming pustular.

One patient was pregnant, and apparently far advanced, but this did not cause any departure from the ordinary symptoms of the disease, and she was discharged before labour came on.

Congestion of the tonsils, though present in several of the cases, was mild, and did not require active treatment.

With regard to treatment, there is little to call for special mention.

Beyond the application of olive oil, which was found very soothing, no treatment was carried out as regards the eruption, and, in fact, it was not needed.

Some of the patients could not be prevented from picking at the eruption when it was in a vesicular stage, and sometimes when it was pustular.

The result, however, seemed to bear out the idea that pricking the eruption is an advantage, not only rendering the patients more comfortable, but also shortening the duration of the attack.

In no case could any resulting injury be noticed.

Sulphurous acid was given in three cases, and, curiously enough, all these were mild, but no definite result can be traced from so few cases. The dose given was small.

For sleeplessness, chloral hydrate, potassium, bromide, and sometimes morphia or tincture of opium was given. The preparation of opium seemed to be especially beneficial.

Stimulants were only given when the symptoms indicated their want, and that occurred in four patients only.

The bowels were kept regular with either calomel and jalap or pulv. glycyrrhizæ (Prussian Pharm.)

Pulv. potass. chlorat. c. sacch. alb. was usually given in soreness of the mouth, and appeared to act very well.

The patients usually complained of great thirst, and acid drinks proved very refreshing.

Towards the end of the attack, each patient underwent a course of Condyl's Fluid baths. These were generally given every alternate day, and the number varied from four to seven.

In cases where nature was assisted in throwing off the pent-up eruption, the parts were rubbed with carbolic acid ointment.

Previous state of health.	Day from Contact.	Day of Month.	Symptoms.	Eruption.	Temperature.	Pulse.	Treatment.
CASE A, ÆT. 28, MALE.							
Unknown.	Unknown.	Oct. 3	On admission the patient was very delirious and maniacal, and required constant watching. No history could be obtained beyond that he had, prior to admission, been a patient in the Melbourne Hospital, from which he had run away. He was covered with a confluent eruption. Tongue dry and coated, eyes deeply congested.	Eruption confluent all over the body; tongue and mouth also covered with eruption. It is becoming vesicular on the face, and is papular on the rest of the body.	M. 99.4	M. 85.	On admission, the patient was ordered Potass Bromid gr. xv. every two hours. Brandy and milk to be given every hour. The hair was cut close; and the bowels kept acting with calomel & jalap. Sedative mixtures were given at night, and at a later stage carbonate of ammonia with squills.
		" 4	Restless and delirious last night and this morning. Tongue dry and coated. Is taking a fair amount of nourishment: milk, beef-tee and brandy.	Eruption vesicular on the face, and becoming so on the arms and trunk.	99.6	98.6	90.
		" 5	Speaks somewhat rationally this morning; had a little sleep last night.	Face beginning to swell; eyes congested and watering.	101.1	101.2	103.
		" 6	Again delirious last night and this morning; does not appear to have any pain, beyond soreness from eruption.	Eruption now vesicular all over the body, and there are some pustules on the face.	101.1	101.2	100.
		" 7	Had some sleep during the night, but is very restless this morning; has slight cough and thick white expectoration; no dulness on percussion; lung sounds healthy. Stool somewhat hard and whitish.	Many of the vesicles about the body have been ruptured owing to the patient's restlessness.	101.6	101.4	115.
		" 8	Still very restless and delirious, requires constant watching; has some pain in swallowing; bowels acting well; stool not so pale this morning; tongue dry; much fætor.—7 p.m., picking at bed-clothes; not taking so much nourishment.	A few pustules on the face have broken, and scabs are forming; strong fætor from body.	102.4	102.3	115.
		" 9	Had some convulsive twitchings during the night. Died 7 a.m.			120.	

CASE B, ÆT. 27, MALE, SINGLE.

Good, but he suffers from deafness.	Unknown.	Sep. 26	Patient states that he took ill on this day, but he cannot give a full account of his illness. It was ushered in with rigors, severe lumbar pains and general malaise and fever.	Day of Eruption.				Acid and Quinine mixtures were ordered in this case, and Chlorate of Potash for the mouth.
		" 29		1	Eruption appeared on the forehead, in the form of small red pimples, which soon spread over the face.	M.	E. 98.4	Potass. Bromide and Chloral Hydrate were given at night, when required.
		Oct. 2	Complains of lumbar pain and (day of cephalalgia, and soreness of the mouth and throat; tongue coated with white fur; bowels regular.)	4	Copious eruption all over the body. It is distinct. There is also an eruption on the tongue and mucous membrane of the mouth. The eruption is in the vesicular stage; the central depression is marked, and the vesicles are surrounded by a red areola.			
		" 3	Face swollen; eyes congested and watering; deafness has increased since he took ill.	5		98.5	98.5	75.
		" 4	Was delirious last night and did not sleep; no cephalalgia, but complains of pains in the legs and back; tongue moist; bowels acting.	6	Eruption becoming pustular on the face.	99.4	98.6	82.
		" 5	Slept 3 hours last night; is taking his nourishment well; pain much less.	7	Eruption advancing to the pustular stage on the rest of the body.	99.3	100.	80.
		" 6	Restless and delirious last night; face much swollen; tongue dry and coated; is taking milk and brandy.	8	Some pustules on the face have broken and scabs forming.	99.6	100.6	90.
		" 8	Slept well last night; tongue not so dry; deglutition not so difficult.	10	Pustules forming on arms and trunk.	100.	100.4	90.
		" 10	Eyes and throat better; no delirium now.	12	Scabs beginning to fall.	99.4	100.	85.
		" 13	Temperature normal; sleeps well; appetite good; tongue clean.	15	Scabs forming on the body and legs.	98.4	74.	74.
		" 17	Patient sat up to-day.	19				
		" 22	Is now able to take some solid food; general health improving.	24	Almost all the scabs are off the face now; some still on the arms and legs.	Temperature continued normal.		
		" 30	Face shows signs of pitting, but only to a slight extent.	32	Site of eruption very red.			
		Nov. 7	Health good.	40	No scabs on body now.			
		" 11	Discharged.					

Vaccinated in infancy; one mark on the left arm.

Previous state of health.	Day from Contact.	Day of Month.	Symptoms.	Eruption.	Temperature.	Pulse.	Treatment.
CASE C, ET. 26 (ABOUT), SINGLE, FEMALE.							
Good.	Cannot be fixed.	Sep. 30	First taken ill with pains in the back, and vomiting, followed by feverishness and restlessness, which continued till the eruption appeared.	Day of Eruption.			
		Oct. 3	.....	1	A rash like that of measles appeared on the wrists and then spread up the arm.		
		" 4	.....	2	Eruption appeared on the face.		
		" 5	.....	3	The eruption spread over the body.		
VACCINATION.	(day of admission.)	" 8	Has a mild attack. No symptoms beyond eruption.	6	There is an eruption all over the body, distinct and sparse; it is in the vesicular stage, and more advanced on the face and arms than on the rest of the body.	M. E. M. E.	
She was vaccinated in infancy, and again ten years ago, but it did not then take. There are three marks on the arm.		Oct. 9	.....	7	Eruption on the face becoming pustular.	100° 100° 98°	
		" 10	Sleeps well; appetite good.....	8	Some pustules have broken, and scabs forming.	100° 100° 98° 100°	
		" 12	.....	10	Scabs beginning to fall off; eruption pustular on body.	100° 98° 98° 74°	
		" 12	.....	11	.....	98° 73°	
		" 16	Patient up to-day	14	No scabs now on face or arms, but a few on the rest of the body.	Temperature continued normal.	
		" 22	General health good	30	Body now clear.		
		Nov. 1	Discharged				

CASE D, ET. 25, FEMALE, SINGLE.

Previous state of health.	Day from Contact.	Day of Month.	Symptoms.	Eruption.	Temperature.	Pulse.	Treatment.
CASE D, ET. 25, FEMALE, SINGLE.							
Good, except that she has always suffered from weak eyes and for about two months before admission she complained of a "scraping" pain in the left eyeball.	Exact date of contact cannot be determined.	Sep. 30	First taken ill; rigor, fever, general pains, especially in lumbar region; diarrhoea; vomiting.	Day of Eruption.	M. E. M. E.		Acid mixtures, and, at a later stage, iron and quinine were ordered. The bowels kept regular with pulv. glycyrr. co. Chloral hydrate and opium were ordered for sleeplessness. A lotion containing four grains of nitrate of silver to the oz. was ordered for the eyes, and counter irritation was applied to the temples, and a clove shade was worn. At a later stage small doses of calomel and opium were given.
Her mother had some operation performed on her eye many years ago.		Oct. 1	Symptoms not so severe late in the day.	1	Eruption appeared in the evening, first on the wrists as a red papular rash.		
		" 2	Diarrhoea and vomiting ceased.	2	Eruption came out on the face.		
		" 4	Throat sore; tongue coated; pain in the back much less.	4	Eruption all over the body (as far as can be ascertained it is vesicular in parts).		
	(Date of admission.)	" 8	Complains of great thirst, sleeplessness, general pains and soreness of mouth and throat; eyes painful and congested, and face swollen.	8	Eruption distinct, but very copious all over the body; on head and face it is vesicular chiefly, some, however, being pustular and globular; areolae distinct, not so advanced in other parts of body; mostly vesicular, but some papular spots are to be seen on the legs and feet.		
VACCINATION.		" 9	No sleep last night; complains of great itching and soreness from eruption; constipation.	9	Eruption on face, almost wholly pustular.	100° 103° 101° 130°	
She has been vaccinated several times unsuccessfully, as was also her mother, but not at the same time as the daughter.		" 10	Delirious last night, but slept towards morning; bowels acting after pulv.; tongue cleaner.	10	.....	101° 102° 126°	
		" 11	Little sleep last night; swelling of face decreasing rapidly; throat and mouth better; eyes getting more painful, cannot bear light, both inflamed, but the left is the worst.	11	Some pustules on the face have broken, and scabs are forming.	102° 101° 99° 99°	
		" 12	.....	12	Pustules forming on legs	101° 101° 113° 110°	
		" 13	.....	13	Scabs beginning to fall off, (and body)	100° 100° 100° 108°	
		" 14	Is sleeping well; tongue cleaning; eyes still painful.	14	.....	100° 100° 98° 104°	
		" 15	.....	15	Scabs forming on legs	99° 100° 99° 100°	
		" 16	.....	16	Scabs falling off rapidly from face & hands	99° 99° 88°	
		" 17	Right eye much better, can now see fairly well with it, but the left is still inflamed and painful, but not so much as before; cornea dull, no ulcer.	17	Eruption slight; pitting to be seen in the face.	99° 99°	
		" 20	General health much better; eye not so painful.	20	Scabs falling off the legs and feet.	Temperature normal & remained so.	
		" 25	Set up to-day.	25	.....	
		" 29	Eyes much improved.	29	Still some scabs on body		
		Nov. 6	Health much improved.	37	Body clear.		
		" 13	Discharged.				

Previous state of health.	Day from Contact.	Symptoms.	Eruption.	Temperature.	Pulse.	Treatment.
CASE E, ÆT. 36, FEMALE, MARRIED.						
Good. She has had seven children, the youngest is five months old and at the breast.	5	Vaccinated.	Day of Eruption.			Sulphurous acid in half-drachm doses was given every six hours, and afterwards every four hours. Fomentations were applied to the throat, and Chlorate of Potash and Sugar given. Sedatives were given when necessary.
	1 to 8	No symptoms beyond those resulting from the vaccination.				
VACCINATION. (Date of admission.) She was vaccinated for the first time on the fifth day after contact.	9	Rigor, lumbar pains, fever.				
	12	Pains general, vomiting, diarrhoea, increased fever, coated tongue.				
	14	Insomnia; other symptoms not so severe.	1			
	15	Sore throat.				
	16	On admission patient complained of general pain, not now marked in the back; thirst, anorexia, insomnia, tongue coated, tonsils much congested, face swollen. Had an attack of vomiting on the way down, and is suffering from diarrhoea.	2			
			3			
	17	Had no sleep last night; pains much less; no vomiting since admission; diarrhoea decreasing; has no milk in the breasts; face much swollen and painful.	4			
	18	Diarrhoea stopped; slept well last night, taking nourishment.	5			
	19	Was delirious last night.	6			
	20	Slight delirium last night, but slept towards morning; throat better; tongue clean; constipation.	7			
	21	Has now some milk in the breasts; takes nourishment well; no delirium.	8			
	24	Appetite good; sleeps well; bowels regular.	11			
	28	General health improving.	16			
	30	Patient up to-day.	17			
	34	General health good; good supply of milk in the breasts.	21			
	40	Discharged.	27			

CASE F, ÆT. 5 MONTHS, FEMALE.

Good.	5	Vaccinated.	Day of Eruption.			
	16 (date of admission.)	The mother being ill herself, did not take much notice of the child till this day, but she states that it was peevish and restless during the two previous days. On admission the patient was restless, but did not appear to have any pain. Slight vomiting; tongue coated.				
VACCINATION. She was vaccinated for the first time on the fifth day after contact.	17	Mother has no milk in the breasts, and the child refuses the bottle.				
	18	No vomiting now; bowels acting; is sleeping well.				
	19	.....			
	20	Is now getting some milk from the mother's breasts.				
	23	Very troublesome and restless the last two days and nights.				
	26	Much quieter and easier.				
	30	.....			
	35	Health good.				
	40	Discharged.				

CASE G, ÆT. 34, FEMALE, MARRIED.

Good, except that she has suffered from enlarged tonsils since she was 11 years of age and is subject to sore throat.	8	Vaccinated (unsuccessfully).	Day of Eruption.			Thirty min- im doses of Sulphurous Acid were given every four hours; fomentations applied
	9 to 10	Headache and slight malaise.				
	10	Rigors, lumbar pains, followed by fever and vomiting.				
	12	Sleeplessness; loss of appetite.				
	13	Sleeplessness; pain in the back much less.	1			

Previous state of health.	Day from Contact.	Symptoms.	Eruption.	Temperature.	Pulse.	Treatment.
CASE G (CONTINUED).						
She has had nine children. (day of admission.)	14	Complains of soreness of the mouth and throat; tonsils enlarged and congested; deglutition difficult; tongue coated with white fur; bowels regular; no lumbar pain; had some vomiting on the way down.	2	M. 98.6	M. 100	to the throat, and Bromide and Chloral Hydrate given when necessary.
	15	No sleep last night; tongue cleaner and throat slightly better; no vomiting since admission; is taking light nourishment; complains of itchiness from eruption.	3	98.6 98.6	112 120	Bowels kept regular by Pulv. Glycyrr. co.
	16	Slept well after draught.	4	98.6 100	116 124	
	17	Slept fairly well without any draught; itchiness passing away; face beginning to swell; eyes congested; constipation.	5	100 101	120 122	
	18	Face much swollen, and the left eye is closed; tongue moist; pulse weak.	6	100 100	118 120	Brandy four ounces.
	19	Complains of throbbing pain in the soles of both feet; face not so swollen; can open the left eye; scabs on the nostrils cause much distress; did not sleep last night.	7	99.8 99.4	113 120	
	20	Swelling of face almost gone; no pain in feet now; tongue coated in the centre; taking food well.	8	98.4	100 82	
	21	.....	9	Temperature continued normal.	80 84	Brandy discontinued.
	22	Tongue clean; sleeping well.	10		76 78	
	23	.....	18		74	
VACCINATION. She has been vaccinated five times. The first was in infancy, and the fourth when she was 18 years old. She was vaccinated for the fifth time four days after contact, but this has not taken. No marks can be found on the arm.	24	[fluid bath for first time.	[disappeared.			
	25	General health improving; had Cond's				
	26	Now well; discharged.	25	Nodules on face almost		
CASE H, ÆT. 50, MARRIED, MALE.						
Good.	4	Re-vaccinated (unsuccessfully).				Thirty minims doses of sulphurous acid ordered every three hours.
	1 to 9	No symptoms.				To take a draught containing twenty grains of Bromide of Potassium and Chloral Hydrate if restless.
	10	Rigors; general pains, especially marked in the knees; fever; loss of appetite; no lumbar pain.				
	13	Symptoms became more severe; slight vomiting; tongue coated. Now confined to bed. Great thirst.	Day of eruption.			
	14	Complaining of sleeplessness.	1	Appeared in the evening on forehead as small red pimples. (and arms.)		
	15	Complaining of sleeplessness.	2	Eruption extended to face	M. 101.4	
	16	Complains of cephalalgia. Has not at any time complained of lumbar pain. Has some difficulty in swallowing. Tongue coated with white fur in centre, moist at edges; bowels confined; eyes congested; suffers from sleeplessness; no vomiting.	3	There is now a copious eruption all over the body, most marked on the face and hands. That on the feet is rather sparse, and the legs are covered with a roseolous rash which is now fading. The eruption is in the papular stage, except on the face, where some spots are vesicular		
	17	Had no sleep last night. Complains of great itchiness of the skin and soreness about the eyes. Bowels acting.	4	Eruption now vesicular over the face, distinct in other places, confluent in others, central depression marked, as also areolae.	99.6 99.6	100 104
	18	Slept for three hours after draught last night, but towards morning he became restless and delirious; face swollen; tongue coated and dry.	5	A few spots becoming pustular on the face and hands.	100.2 100.6	116 118
	19	Slept for five hours last night after draught; no delirium; feet and hands swollen and very tender from the eruption; tongue coated, but moist at tip.	6	Eruption seems no have been arrested in its development in the trunk and arms.	101.2 100	120 118
VACCINATION. (Date of admission.) He was vaccinated in infancy, and has three marks on the right arm. He was re-vaccinated on the fifth day after coming in contact with a person suffering from variola, but unsuccessfully.	20	Restless early part of night, and had draught at 10.30, and slept afterwards; slight cough; tongue cleaner; pain in hands and feet much less. Taking a fair amount of nourishment.	7	Some pustules on the face have broken, and scabs are beginning to form. The eruption on trunk, arms, and legs is drying, some being in the papular, others in the vesicular stage.	99.4 99.4	102 100
	21	Slept well, without draught, no pain; bowels regular.	8	Most of the pustules on the face have now broken.	98.4 98.6	98
	22	Slept last night without any draught.	9	Eruption on legs and arms existing as reddish brown spots.	98.4	76 76
	24	[health improving.			Temperature continued normal.	
	25	Temperature continues normal; general	11	Scabs falling off face.		
	26	Sleeps well; good appetite; bowels regular	12	Scabs coming off body.		
	27	Health much improved.	14	Scabs off face and hands.		
	28	Had Cond's fluid bath for first time. No scabs on body now; general health good.	21	No scabs on body now.		
	48	Has had seven disinfectant baths. Discharged.				

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, FEBRUARY 15, 1885.

EDITORIALS.

THE CONTAGIOUS DISEASES ACT IN QUEENSLAND.

A RESOLUTION recently passed in the Queensland Legislative Assembly, in a very thin house, by the barest majority, recommended the revocation of the Contagious Diseases Act in force in that Colony, which authorises the periodic inspection of prostitutes, and provides for their compulsory treatment and restoration to health before they are allowed to exercise their calling. No thinking person can, for a moment, doubt the public advantage of such power as is given under this Act. It is the only means by which syphilis, one of the greatest evils with which the race has to contend, can be kept in the slightest control. The arguments used against it are, first, that it protects the guilty sinner, and gives safety to the experienced *débauché* in his *amours*. The persons who take this line must be grossly ignorant of the ways of the world, or they would realise that the experienced sinner knows too much to need such protection, and is quite able to take care of himself, that his *liaisons* are more frequently carried on with women who would not be liable to inspection.

The individuals who are the greatest sufferers from uncontrolled venereal disease are the absolutely or comparatively innocent—the wives of men who, in a momentary departure from the path of virtue, perhaps, at a time when excited by alcohol, contract the disease, and afterwards infect their wives before they are aware, in their inexperience, that they have it themselves. Boys who, on their arrival at puberty, give way to their recently developed sexual feelings, and who, not knowing the terrible risks they run, have connec-

tion with infected women. Also young girls, yielding to the solicitations of some scoundrel, infected with the disease, without the single spark of manhood which would prevent him inflicting lifelong misery on his unfortunate victim.

These are the people who principally suffer, and who, from ignorance of their danger and from fear of exposure, allow the disease such a start as to render its eradication from their systems impossible, and who, if they recover comparative health, become the parents of infected offspring, and the progenitors of a diseased and stunted race.

And as regards the second objection, that it may be made the means of oppression, we admit that there is more in this argument than in the other; but it depends on the way in which the higher authorities supervise the action of their subordinates how much this evil amounts to. One case only seems to have been quoted by the supporters of the resolution, and the remarks made to the girls, charged under the Act, by the Police Magistrate who tried them, show how fallacious this case was.

The medical profession stands too high in the estimation of the world to be in the slightest degree affected by the remarks of one of the Members who, in his speech, said:—"Am I to regard the opinions of doctors who receive a paltry salary for examinations under the 'Contagious Diseases Act.' I view them with a feeling akin to scorn. I do not give them any weight at all." This honourable member, from the account we hear of him and his antecedents, is not in a position to make his opinion of much weight or value, and probably the profession could receive no greater compliment than his enmity. His scorn is very much akin to that of the drunken mendicant for the gentleman who has refused him a shilling. His loud-mouthed assertions on this and on every other subject on which he is so dotingly fond of airing his eloquence, are just in reverse proportion to his knowledge of the subject, and but sustain the character he has, by years of residence, gained amongst his fellow colonists, which, in his case, makes particularly apt the old, old proverb, that "Familiarity breeds contempt."

We especially call the attention of our readers to the paper of Dr. Rowling on Vaccinia and Variola, published in this issue. We consider it one of the most valuable contributions to medical science which has been recently made public, and should do what mere assertion can never do, give confidence to the public as to the infinitesimal risk that exists of conveying other diseases than cowpox by carefully performed vaccination.

ANOTHER SMALLPOX PROSECUTION IN SYDNEY.

On January 18, Mr. William Moore, an unregistered medical practitioner, who styles himself "Homœopathist," pleaded guilty to having failed to report a case of smallpox which he was attending, and was fined £50. The Inspecting Medical Officer of the New South Wales Government found it to be an unmistakeable case of variola, the seriousness of which was proved by the death of the patient a few days after her removal to the quarantine station. Mr. Moore, in a letter of excuse to the health authorities, gives a history of the case, which indicates that he saw and noted symptoms which were typically those of the early stages of smallpox, but did not recognise them as being such. This non-recognition is easily accounted for, as he says "the symptoms being so unlike what I had read and seen by photographs," thus implying that this had been his only means of knowing anything about the disease. No doubt he did his best and, had he known what was under his nose, would have complied with the law, and reported the case to the authorities; this is shown by his having since given notice of two other cases to them, which, however, did not resemble the smallpox, which he supposed them to be. His treatment as stated by himself is novel, but judging by the result of the case, not so effective as it is natural to expect from a practitioner who gets his knowledge by direct inspiration without teachers or attendance at any school of medicine. He saw her on December 15, again on the 16th, and goes on to say, "on the 18th I was sent for, as a strong scarlet rash had come out, large, irregular elevations, with several shotty elevated spots." For this he applied a "German Oil;" next day he ordered an application of "baking soda and water," and advised "Household Remedy Ointment." The fell disease however did not yield to this treatment, and a knowledge of the case coming to the ears of the authorities, the patient was seen by their medical officer and removed to the quarantine ground, the woman dying a few days after admission.

Mr. Moore, in his evidence given before a select committee of the Legislative Assembly, says he has been practising as a medical practitioner for twenty years, and that prior to this he had not any knowledge of medicine, and that he had had no practice in anatomy or physiology. He also says he now has arrived at such a pitch of knowledge as to be

able to distinguish between a cancerous and a non-malignant tumour, by finding in the one case cancer cells in the blood, and not in the other when placed under the microscope. This is certainly a discovery in pathology only likely to be found out by an untrained man such as this practitioner states himself to be. He is, however, sufficiently modest to say that he would not submit himself to examination to prove his fitness to practice, "because I have never gone through a course of medical study," but goes on to say that he daresay he could pass in three months with the aid of a Grinder's book which he has in his possession. Happy man and transcendent genius to be able to do in three months with the aid of his solitary book what it takes ordinary men at least four years, spent in dissection, attendance at lectures, and hospital practice, besides hard reading at other times, to obtain. The above case shows the state of the law in New South Wales with regard to medical practitioners, with a force which no comments from our pen can enhance, and we can only again reiterate it is not the qualified medical practitioner who suffers by this state of things, but the greenhorns amongst the public who employ these untaught geniuses so common in New South Wales.

A CLERICAL GOVERNMENT VACCINATOR.

In the New Zealand Government Gazette is a notification, dated January 27, 1885, of the appointment of "The Rev. James McWilliam" as a Public Vaccinator. We hope, in the interests of the public and of vaccination, that it was proved that he possessed a proper knowledge, and had received an adequate training in the principles and practice of vaccination before the authorities took upon themselves to appoint him. If they failed to do this, they have grossly and lamentably misused their position as guardians of the public health. Every medical man possessing a British qualification must produce a certificate from some gentleman (specially appointed for the purpose) that he has been trained and examined as to his practice and knowledge of vaccination before he is admitted for examination for his diploma. If the Rev. J. McWilliam has also thus proved his fitness, and is not one of the "minor nuisances" alluded to in our December number, by our correspondent "Maori," as existing in New Zealand, we have nothing to complain of.

TOUTING BY QUALIFIED MEN.

OUR attention has been called to the fact that more than one member of the profession in these colonies is in the habit of distributing printed circulars containing complimentary testimonials as to his professional abilities; in some instances this has even been done personally by the practitioner himself. Those men who have so little sense of the dignity of the profession to which they belong, and whose advertising and commercial instincts are so strongly developed as to necessitate their toutting for employment, have good grounds of complaint against their guardians in forcing them unnaturally into a learned profession, when they are so much better fitted for the calling of a cheap grocer or draper, in which their advertising talent could be so legitimately and advantageously employed. Amongst the sinners is one who fills an honorary appointment in one of the leading hospitals in Australia. It is to be regretted that the public do not sufficiently realize the fact that, the higher the professional attainments of the practitioner, and the greater the mental capacity and sense of honour which he possesses, the less likely is he to resort to such derogatory means of letting his attainments be known, and that nothing really is a greater proof of the inferiority of the man than that he finds it advisable to publish what other but more refined men probably possess in a higher degree, but do not find it necessary to trumpet forth.

ON January 12, Dr. Foreman removed, per vaginam, the cancerous uterus of a patient at the Prince Alfred Hospital, Sydney. The woman has made a good recovery and will shortly be discharged well. The operation presented some more than usual difficulties, and the satisfactory recovery is a matter for special congratulation. We are promised a full report of the case, which we hope to publish shortly. This is the second operation of the same character done by Dr. Foreman during the last few months, and both have been equally successful. We believe these cases are the only ones hitherto operated on in this manner in the southern hemisphere. Since the beginning of 1884 there have been four cases of extirpation of the uterus performed in Sydney, all of which have recovered, and the patients have since done well; two by Dr. Foreman, per vaginam, and one each by Drs. Fortescue and Goode by abdominal section.

A CORONER AND AN UNREGISTERED PRACTITIONER.

By a report in the *Sydney Daily Telegraph* of Feb. 11, it appears that an inquest was held by the acting coroner, Mr. W. T. Pinhey, on the body of Ann Holden. The paragraph says that the body was seen by "Dr." MacMahon, of Crown-street, shortly after death, and that "the acting coroner directed that gentleman to make a post-mortem examination." If this newspaper report is correct, it shows a singular want of knowledge of one of the most important rules which should guide him in the duties of his office, for he should have known, as well as ourselves, that "Dr." MacMahon is not, and, without some years of study and the acquirement of fitting diplomas, is not likely ever to be on the register of Medical Practitioners of New South Wales. This incident appears to show a similar carelessness with that of the Pharmaceutical Society in placing the name of Thomas Hamilton Clarke on the list of that Society, of which the same Mr. Pinhey is also secretary.

LEADING ARTICLE.

AMBLYOPIA ALCOHOLICA.

By B. SCHWARZBACH, M.D., L.F.P.S., Glasg.,
Wellington, New Zealand.

My friend, Dr. Uhthoff, in Berlin, has forwarded to me a paper which he recently read before the Berlin Medical Society. The subject is: "On the changes in the interior of the eye caused by alcoholism, and on some pathological-anatomical changes in amblyopia alcoholica." The contents of the paper are interesting in a high degree, and I believe that the readers of the *Australasian Medical Gazette* will be pleased to have a short synopsis of the same; for it is the first time that the subject has been treated somewhat exhaustively. In addition to Dr. Uhthoff's researches, I shall give my knowledge of the literature in analogous cases.

It is well known to specialists that alcohol is far the most frequent cause of the typical amblyop. intoxicat., with central scotoma and free field of vision. Weak sight, caused by excessive smoking alone, is not nearly so frequent. In most cases both—drink and smoking—will unite their injurious effects on the nervous system.

To illustrate how frequently disorganisations at the back of the interior of the eye will occur through abuse in alcohol, Uhthoff publishes the

result of his ophthalmoscopic examination which he has made for more than two years in the lunatic department at the Charité in Berlin. Amongst the cases examined were 360 pronounced "Alcoholists," I mean persons who were mentally deranged through excessive drink (delir. trem., epilepsy, etc.) In 14 per cent. out of the above number a slight, yet easily recognisable and equally diffused opaqueness—better cloudedness—of the retina was detected, which was most marked near the papilla optica, sometimes extending to the periphery of the retina. Especially the medial half of the papilla is somewhat obscured, the retina reflects slightly greyish, and the whole of the ophthalm. aspect is less clear than in normal cases. The papilla, the margin of which is not clearly defined, has, as a rule, no sign of hyperæmia, and the sight seems only a little disturbed. Diagnostically this ophthalmosc. appearance is of little value only. We may, perhaps, consider such cloudy state of the retina to be a preliminary sign of the approach of amblyop.-intoxic., but we have no certain clue for its positiveness. It may be possible—and it has been stated by others—that in "fresh" cases of amblyop.-alcoholica a retinal picture, as described, may be found, but the material is not sufficiently large yet to express a decided judgment thereon. One thing, however, is certain: an ophthalmosc. picture, as described above, must be considered to be a pathological sign in connection with alcoholism—although it is not characteristic in itself.

Independent of opacities in vitreous body, of medullated retinal fibres, cataract, plaques or chorioidea, and other casualties found accidentally connected with amblyop.-alcoh., Uthoff made the following observation: In 1 per cent. of the "Alcoholists" examined, retinal hæmorrhage existed, in two cases of which patients had also rupture of bloodvessels in conjunction, while the third patient suffered from nephritis. There can be no reason to believe that the retinal hæmorrhages are connected with alcoholism. In some cases patients complained of diplopia, which lasted for a few days or a few weeks, and which, at the time of the examination, was not the result of a paralytic state of the muscles of the eyeball.

Far more important than the stated symptoms in amblyop.-alcoh., seems to be a pale discoloration of the lateral part of the papilla optica, the result of an atrophic process. The same has been known and described by others (for instance, by Leber of Jöttingen), but Uthoff wishes to make two distinct corrections of the former version of this phenomenon. He says that the expression, "a paleness of the lateral half of the papilla," is not quite correct, as not the full half of the papilla is discolored, but only a section of it, often not more

than one-fifth of the circumference of the whole. And further, this state is not always complicated with weak sight; it may exist with any visual disturbance of a present or past nature. Amongst the 360 cases such an atrophic discoloration was found 61 times=17 per cent. Sometimes the margin of the diseased and healthy parts of the papilla was strongly defined, and then the whole ophthalmoscopic picture was beautifully clear. But even in cases where the margin was less marked, where the atrophic parts only gradually extended into or from the normal parts, there was no difficulty in verifying the observation, especially if the upright picture was used. Such an ophthalmosc. observation must be of great diagnostical help in lunatic asylums—as regards alcoholism. Of course other causes may produce amblyopia with scotoma centralis (such as tobacco, diabetes, lead, neuritis retrobulbaris, etc.), and may produce also the stated discoloration of papilla, but these causes would be easily detectable, and they certainly do not impair the value of the statement above.

Until Uthoff's researches on the pathological-anatomical changes in amblyop.-alcoh., only isolated cases had been under the dissecting knife. Erismann in Zürich (Ueber Intoxicationsamblyopie, Zürich, 1867) had opportunity to examine thus the optic nerves of a patient who had suffered seriously from alcoholism. The cross-cut of the nerves showed "punctated, greyish, gelatinous spots." Microscopically, "extensive thickening of the neurilemma of the optic nerves, and of those fibre-layers which are connected with the same." A second case was published by Leber (Handbuch v. Graefe und Saemisch, Bd. V., p. 882). He found degeneration of the superficial fibre-layers below the neurilemma. But this case had not been a pure amblyop.-intoxicat., the field of vision being reduced, and retinal changes were existing as well. Samelsohn (v. Graefe's Arch. f. Ophthalm., Bd. XXVIII.) very clearly describes a third case, and he traces the macular fibres of the optic nerves as far as the canalis opticus. The partial atrophy was of a neuritic origin near the canalis opticus on both sides, and on one eye, also direct behind the bulbus—the parts between showing more the sign of a simple degeneration. Nettleship and Edmunds Walter (Transact. of the Ophthalm. Society, Vol. I., 1882) published together one case where both papillæ were examined with the adhering parts of the optics. The patient had had scotoma centralis, was diabetic, and an excessive smoker. Vossius (v. Graefe's Arch. f. Ophthalm. XXVIII., p. 201), and very recently Bunge (Halle, 1884) have had occasion to examine two more cases of a similar kind, but with no new results.

Excepting these six quoted cases, I was not

aware of any other publication of similar examinations until I received Uhthoff's paper in regard to two other patients who had been afflicted through alcoholism. In one of the cases the above described discoloration of papilla was most beautifully discernable. Patient previous to death (he died in the lunatic department of pneumonia), was proved to have scotoma centralis and free field of vision. S= $\frac{1}{10}$. The dissection showed oedema of the meningeus. The history of the second case I give with the author's own words: "Patient suffered repeatedly from delir. trem., had moderate neuralgic pains in the legs, strong sensitiveness of muscles against touch, increasing paralytic state, and loss of volumen of muscles, changeableness in regard to electricity, repeated ruptures of small blood vessels on the extremities, swelling of the gum, and he was very anæmic. Death occurred after three months and a half. The ophthalm. inspection showed also here a decided atrophic paleness in the lateral part of the papilla. Sight was pretty good, about $\frac{3}{4}$. Patient could read Sn. 1 $\frac{1}{2}$ with help of strong convex glasses; scotoma centralis could not be detected with certainty. According to the history of the case, it was known that about a year previously patient could recognise things only as through a heavy cloud; the eyes were not inflamed. There is no doubt of the nature of the former weak sight (amblyop.-alcoh.)

We find now both cases supplementing themselves happily in regard to the disease as such, and in regard to the ophthalmoscopic picture. The last is similar in both cases, yet the power of sight is quite different. The one case proves to what a high degree of degeneration of nervous substance the disease may lead to; the other showed also a typical amblyopia potatorum, from which, however, patient sufficiently recovered so as to have good use of his eyesight. Here we find the quoted atrophic discoloration of the papilla (consequently, some anatomical disorganisation) and yet the sight is not much impaired. But not only the ophthalm. aspect, but also the result of the microscopical examination is very similar in both cases, the only difference lies in the intensity of the process. The commencement of the neuritic process is easily traceable to the orbital part of the trunk of the optic nerves.

I omit to give details of the anatomical changes of the objects in question, as shown by aid of the microscope. Uhthoff has sent me ten microscopical preparations (horizontal and vertical cuts) of the optic nerves of both patients. I am very willing to lend the plates for examination to any medical man who takes sufficient interest in the matter. The degenerated parts of the nerves are situated on the lateral side of the central vessels, and extend peripherally.

THE MONTH.

NEW SOUTH WALES.

THE Council of the Linnean Society of New South Wales again offers a prize of £100 for the best essay on "The Life History of the Bacillus of Typhoid Fever." The essay must be based entirely on original research, the details of which, and of the methods employed are to be fully explained; must be in English; must be distinguished by a "motto," accompanied by an envelope containing the author's name; and must be delivered at the Society's House, 54, Phillip-street, Sydney, on or before December 31, 1885.

At this month's meeting of the Senate of the Sydney University, the medical faculty called attention to a question whether the present arrangements for the appointment of medical officers for the St. Vincent Hospital afford a sufficient guarantee for their qualification for clinical teaching to university students, and it was resolved, on the motion of Dr. Renwick, seconded by Sir P. Jennings, "That it be referred to the Faculty of Medicine to prepare and submit general rules for regulating the recognition of hospitals for the purposes contemplated in by-law 97."

At the Sydney Water Police Court, on January 13, Mr. William Moore, a homœopathic practitioner, was proceeded against by Mr. Edmund Sager, secretary of the Board of Health, for a breach of the Infectious Diseases Supervision Act. The information charged the defendant that on the 22nd December last he was attending a case of eruptive fever which might reasonably be supposed to be small-pox, in a house at Botany Road, Waterloo, and did not immediately report in writing the said case to the proper authorities. The defendant pleaded guilty, and was fined the maximum penalty of £50, with £2 7s. 6d. costs, or three months' imprisonment. The fine was immediately paid.

THE number of patients admitted into the Sydney Hospital from the 1st January to 31st December, 1884, has been 3184. Of these 1695 were surgical, and 1489 medical cases. 2365 were males and 819 were females. The largest number of admissions was in the month of May, 306; the smallest in the month of January, 249. The number of accidents and urgent cases attended to by the resident medical staff, but not admitted, has been 3157. The number of patients treated at the outdoor ophthalmic department for the year ending 31st December, 1884, has been 509. The number of deaths during the year has been 334, viz., 253 males and 81 females. Of these 101 died within 48 hours of admission. The number of patients remaining in the house on 31st December, 1884, was 201. The number of cases treated by the district surgeons in connection with the dispensary has amounted to 9020. Of these 764 were visited at their own homes.

In the Grafton Hospital 119 patients were treated during the past year, of whom 56 were discharged cured, 35 were relieved, 7 were sent to the Benevolent Asylum, 8 died, and 15 remained in the hospital on December 31.

At the West Maitland Hospital 30 fever cases were treated during the past year, of which number 5 died, 12 operations were performed, and with one exception, they were successful: 117 out-door patients and 198 in-door patients were treated during the year. Of the latter 100 were discharged cured, 71 relieved, and 13 died. Drs. R. G. Alcorn, W. D. Power, and S. A. Alcorn were elected medical staff, in addition to Dr.

R. J. Pierce, who for some years has been consulting surgeon.

As a tribute to the memory and token of great esteem in which the late Dr. T. Howe, one of the hon. surgeons to the West Maitland Hospital, was held, the committee have procured an enlarged portrait of the doctor, to be hung in the committee-room, with the portraits of other gentlemen who devoted much time and means to the benefit of the institution.

DURING the past year 187 patients were admitted into the Wagga Wagga Hospital, of whom 120 were cured; the daily average of patients, 16; deaths 25, 11 of which were cases *in extremis*, the patients dying within four days of admission.

THREE fresh cases of small-pox occurred in the Redfern district, Sydney, on January 18.

A CASE of small-pox was discovered at West Maitland on January 30.

TYPHOID, scarlatina, scarlet fever, and whooping cough are prevalent in the Penrith district; a number of deaths have taken place, principally among young children.

A RESIDENT of Bowna, near Albury, and four of his children, had a narrow escape of being poisoned through eating tinned fish.

DR. T. D. ATKINS, of Oondobolin, has removed to Candelo, a small post town, 260 miles S. of Sydney. His predecessor at the latter place, Dr. G. L. L. Lawson, has left for New Zealand.

DR. H. R. BELL has been appointed Member of the Licensing Court for the district of Murrurundi.

DR. A. C. BROWNLESS, of Hyde Park, Sydney, has been elected, by an overwhelming majority, medical officer to the Australian Union Benefit Society. There were ten applicants for the position.

MR. JOHN HAY CAIRD, J.P., L.R.C.S., Edin., 1878, district Govt. Medical Officer and Public Vaccinator, died at his residence, "Hartwell," Kiama, on February 1.

DR. W. S. CORTIS, sen., has settled at Port Macquarie, at the mouth of the River Hastings, 256 miles N. of Sydney.

DR. L. G. DAVIDSON has succeeded to the practice of Drs. Jones and Macqueen, at Balmain, a suburb of Sydney. Dr. Jones intends going home, and Dr. Macqueen has commenced practice at 178 Liverpool-street, Hyde Park, Sydney.

DR. H. M. C. DALTON, late of Newcastle, has settled at Condobolin, in a rich agricultural and pastoral district, 311 miles W. of Sydney.

DR. C. J. DE VIE, late surgeon to the Charters Towers Hospital (Q.), has succeeded to the practice of Dr. L. G. Davidson, at 54 Newtown-road, Darlington, Sydney.

MR. ROBERT JOHN ALGERNON DOBIE, M.R.C.S.E., et L.S.A., Lond., 1875, late medical officer to Balranald Hospital, died at Muswellbrook last month. The deceased gentleman was formerly surgeon to the Salford and Oldham Medical Mission Dispensaries, and hon. surgeon to the Great Cheetham-street Home for Women, also resident medical officer to the Dover Hospital and Dispensary.

DR. CHAS. DOWD, late of Thornborough (Qu.), has commenced practice at Gulgong, a mining town 202 miles W. of Sydney.

DR. THOS. FIASCHI has returned from his trip to

Europe and resumed practice at 39 Phillip-street, Sydney.

MR. ROBERT HAVENS, M.R.C.S., Eng., et L.S.A., Lond., 1831, died at his residence at Reidsdale, near Braidwood, on February 8, at the ripe age of 78 years. The deceased gentleman lost his sight through an explosion of chemicals about 30 years ago, and did not practise his profession for many years past.

DR. H. LILIE has commenced practice at 177 Liverpool-street, Hyde Park, Sydney.

MR. FRANCIS WALTER GRIERSON, M.B. et Ch.M., Edin., 1883, late resident medical officer at the Prince Alfred Hospital, Sydney, died on January 8, at Nepean Towers, Douglas Park, at the early age of 24 years.

MR. THOMAS HOGG, J.P., vice-president of the N. S. Wales Benevolent Society, died at his residence, Darlington House, Newtown, Sydney, on January 28. Mr. Hogg was formerly a surgeon in H.M. East Indian army, also medical officer to the Neillgherries Sanatorium, General Hospital and Native Infirmary, at Madras. He came to New South Wales in 1837, in medical charge of military prisoners under sentence of transportation.

DR. KENNEDY and DR. WOODS have been appointed surgeons to the Albury Hospital for the ensuing twelve months.

DR. L. G. MALLAM, a native of West Maitland, having just returned from England, has commenced practice at Armidale, the capital of the New England district.

DR. W. H. PAGE, late of Newcastle and Wagga Wagga, who recently went home to England, has died from paralysis of the tongue and throat.

DR. W. O. WILKINSON, late of Hereford House, Glebe, Sydney, is returning to the colony by the P. & O. steamer "Parramatta," which sailed from London on January 15.

DR. E. R. SMITH, late of Carcoar, has just returned to the colony from his trip to England.

DR. C. G. THORP has commenced practice at Pictou, in an agricultural district, 53 miles S.W. of Sydney.

DR. WORRELL, a new arrival, has commenced practice at Waverley, a suburb of Sydney.

NEW ZEALAND.

THE following gentlemen have resigned their appointments as Coroners within the colony, in accordance with a resolution of the House passed last session, to the effect that medical men in practice should not hold the office of coroner:—T. Bennett, L.R.C.S., Irel., of Johnsonville; J. Drysdale, M.D., of Port Chalmers; A. G. Duff, M.D., of Stoke, Nelson; J. D. Frankish, M.D., of Christchurch; T. Hitchings, M.R.C.S.E., of Napier; H. McCaw, M.B., of Mosgiel; F. A. Monckton, M.R.C.S., of Kumara; M. Morris, of Amberley; J. M. Gibbes, Esq., of New Plymouth; J. Reed, M.R.C.S.E., of Waipukurau; A. Todd, M.D., of Waipawa; J. G. F. Wilford, M.R.C.S.E., of Hutt; and H. W. Watling, M.R.C.S.E., of Waimate, Bay of Islands.

THE following gentlemen, viz., Dr. T. M. Hocken, of Dunedin; Dr. J. G. Smith, of Balclutha; and Dr. J. E. Trevor, of Ashburton, who refused to retire, have been removed from their offices of coroners by the Government.

A PUBLIC inquiry by the Christchurch Hospital Board, into the occasion of Dr. Nedwill's resigning his position on the hospital staff, is exciting great interest in Christchurch. It appears that Dr. Stewart performed an operation for hernia on a patient, since dead,

to whom the risk had been explained, but who urged that it might be performed. Dr. Nedwill's chief complaint is that no consultation of the staff had been held, as provided by the rules, prior to the major operation, but a number of side issues appeared to be raised during the course of the inquiry. Dr. Stewart admits that no consultation was called, but pleaded that the urgency of the case would not admit of delay.

DR. J. J. BROWNLEE, late of Derrylard, Portadown, Ireland, has commenced practice at Mason's Flat, Waikari, province of Canterbury.

MR. HENRY WILLIAM DIVER, J.P., L. et L. Mid., 1869, M., 1877, R.O.P., Edin., M.R.C.S.E., 1867, honorary medical officer to the Wellington Hospital, surgeon to the Maori Prison and the Volunteer Naval Brigade, died at his residence, Wellington, on January 13, after a prolonged illness.

DR. HAINES, of Alten-road, Auckland, is about to visit Europe for twelve months. Dr. Macmullen takes charge of his practice during his absence.

DR. G. A. D. MAHON, late of Aspley Guise, Woburn, England, has settled at Caversham, a suburb of Dunedin.

DR. G. P. RICHARDS, of Palmerston North, has removed to Feilding, in a farming and grazing district, 107 miles N.E. of Wellington.

DR. T. B. WHITTON, late surgeon to the Mount Ida Hospital, Naseby, has removed to Reefton, a gold-mining township, 53 miles S. of Westport.

QUEENSLAND.

THE building of the Cloncurry Hospital, which was in a fair way of being commenced, is unfortunately delayed for at least six months, and perhaps longer, owing to a misunderstanding between the Government and the subscribers.

DR. J. G. BLACK, late of Mittagong (N.S.W.), has settled at Gympie.

DR. G. W. MACARTNEY, late of Ipswich and Normanston, has commenced practice at Townsville.

DR. D. B. RICHARDS, formerly of Halifax, Nova Scotia, has commenced practice at Rockhampton.

DR. M. SOULE has resigned his appointment as Assistant Health Officer at Townsville.

SOUTH AUSTRALIA.

THE number of insane patients treated in the Adelaide and Parkside Asylums during the year 1884 was 880, viz., 515 males and 365 females. Of these 127 were discharged recovered or improved, and 64 died; the number remaining in the asylums on the 31st December, 1884, was 684. The ratio of admission to population was 1 in 1,523.

DR. E. C. STIRLING, M.P., Lecturer on Human Physiology at the Adelaide University, is a passenger by the P. & O. steamer "Pekin," which is due in Adelaide early in March.

TYPHOID fever has broken out among the men employed on the Government works at Herrgott. The cause is attributed to the quality of the water supplied to them.

DR. JAS. MILNE, a recent arrival in the colony, has commenced practice at Wirrabara.

DR. C. G. D. MORIER, who lately settled at Morphetts Vale, has removed to Nairne, in an agricultural and pastoral district, 25 miles E. of Adelaide.

VICTORIA.

THE Chief Secretary of Victoria intends to reorganise the Central Board of Health, and as a commencement Mr. J. J. Shillinglaw, the secretary, now on leave of absence, will be transferred to another branch of the public service.

THE Medical Board passed a resolution at their last meeting that the Chief Secretary should be requested to appoint Dr. Youl the permanent chairman of the Board.

A MEMORANDUM has recently been forwarded to the Chief Secretary by the Central Board of Health, urging the absolute necessity of establishing a Lock hospital in or near the city.

FROM the annual report of the Melbourne Eye and Ear Hospital, we learn that during the past year the benefits of the hospital have been eagerly sought by the public—out-patients numbering no less than 14,396; new cases, 2,316; and in-patients, 429. Of these a large proportion has derived permanent benefit. Operations, 468. The committee also acknowledge the valuable services rendered by the hon. medical officers of the hospital, who have generously devoted their time and skill to the cause of public charity.

AT the Echuca District Hospital 212 in-door patients and 360 out-door patients were treated during the past year, the daily average of patients being 13 per cent. higher than the previous year.

FIVE deaths from diphtheria have lately occurred at Penshurst, in the Western district. All the members of the Central Board of Health are of opinion that the swamp in the vicinity of the township is the source of the contagion. At the suggestion of Mr. Newbery the board decided to recommend to the local board the use of sulphate of iron with a view to destroying the disease germs in the swamp.

MR. EDWARD DAVY, J.P., L.S.A., Lond., 1827, M.R.C.S.E., 1828, the alleged discoverer of the "relay" system, by which the electric telegraph has become what it is, died at Malmsbury, on January 26, aged 79 years.

DR. W. R. ALLEN, late of Ballarat, has removed to Kingston, a gold-mining township, 115 miles N.W. of Melbourne.

MR. HENRY DACEY DEAN, J.P., M.R.C.S.E. et L.S.A., Lond., 1855, died suddenly from heart disease, at his residence, East Charlton, on January 11, aged 52 years.

DR. H. C. JEE, of Mount Wycheproof, has removed to Charlton, on the Avoca river, 173 miles N.W. of Melbourne.

DR. C. C. M'FARLANE has taken up his residence at No. 2, Royal-terrace, Nicholson-street, Fitzroy, a suburb adjoining Melbourne, and commenced practice in conjunction with Dr. Wm. Crooke.

DR. W. S. FLETT, a new arrival from Edinburgh, has commenced practice at 5 Barcelona-terrace, Brunswick-street, Fitzroy, a suburb adjoining Melbourne.

DR. FITZGERALD, of Melbourne, is a passenger by the P. & O. steamer "Pekin," which left London for Australia on January 29.

WESTERN AUSTRALIA.

DR. ADAM JAMESON, late of Frederick-street, Edinburgh, has commenced practice at Perth.

CORRESPONDENCE.

VACCINATION.

(To the Editor of the A.M.G.)

SIR,—In view of the present outbreak of smallpox, it is much to be deplored that the leading newspaper of this colony should exhibit such lukewarm views on the value of vaccination. In extenuation of its silence, it may plead, of course, the technical nature of the question, and the subject being a scientific one, we cannot help believing that hitherto the editor has looked upon it as such, and, therefore, beyond the pale of his legitimate criticism. But if, on the one hand, he will reflect on the serious nature of the disease that vaccination is calculated to control and how serious it is, he would be horrified if he could come to the hospital and see, and would deem immunity from it cheaply purchased at any risk; and if he will consider, on the other hand, the overwhelming amount of testimony, in favour of vaccination, from some of the greatest physicians the world has ever seen—and from such men as Seaton, Simon, Farr, Ballard, Parkes, Marson, and a host of others whose names are immortal; and, further, if he will

"Cast a moment's fair regard"

to the place in professional estimation that the anti-vaccinators of the profession have attained to—(they have had notoriety, but never fame)—he will, we feel assured, not only give his hearty assent to this, the greatest of all life-saving operations which we know, but recognising that it is so, he will persistently advocate, with that trenchant pen he knows so well how to wield, this, the only rational and efficient remedy for the danger. And let us hope that he will not cease to do so, until the people of New South Wales rise up in a body and demand from the Government a Compulsory Vaccination and Revaccination Act.

I fear that in this very word "compulsory" lies the clue to all the thoughtless clamour against the introduction of such a beneficent measure. "The liberty of the subject" is thought to be in danger. Yes; his liberty to die and to carry disease and death into the streets would be compromised, I admit it. What member of Parliament would go to his constituents with a promise that, if they would support him, he would ask the Government to throw open the gates of Gladsville, because there "the liberty of the subject" was interfered with? None. And, yet, the non-vaccinated person is more dangerous than the maniac, always dangerous to himself wherever he goes, and a firebrand in a magazine, should he contract varicellous disease and approach to others who are unprotected. Nor must it be forgotten that, even in well-vaccinated communities, such a person is dangerous; vaccination is not always thoroughly done, protection wears out, and re-vaccination is postponed. The abstract postulate will, at once, be conceded by everyone—that so soon as the subject becomes dangerous to his fellow-subjects, it is time his liberty was interfered with. The folly of the anti-vaccinator is often a *felo de se*, but, unhappily, it is too often something more, and the sinner he is given to clearly understand that the better.

I trust the time is near at hand when, all prejudice having been set to one side, this question will be viewed by the leaders of the people, both press and parliamentary, in that calm and philosophical spirit which

alone befits a scientific subject of such vast importance to the welfare of the people.

And, in the meantime, I have one or two suggestions to offer to our professional brethren, which, if carried out, would, I feel sure, do something to hasten the time.

First.—A short statement of the nature and advantages of vaccination and revaccination, with the opinion of the most eminent authorities on the subject, should be printed, and sent with a letter to every qualified practitioner in the colony for his approval and signature.

Second.—A memorial to the Government, praying for legislation on the subject and asking for compulsory vaccination at three months, and revaccination at or about puberty, should be prepared at the same time, and also forwarded to every medical man for his signature.

Third.—No number of the medical serials should be issued without either a leader or some prominent article on vaccination.

Fourth.—The said statement, memorial, and journals should be presented to Parliament and posted to each individual member.

Fifth.—The said statement and memorial, with signatures attached, should be published in every newspaper throughout the colony.

Sixth.—Such articles, from the leading medical journals, as bear upon the question, should be sent to the daily papers for republication.

Seventh.—In the compilation of school and college text books, the subject should not be forgotten. Such instruction is of equal importance with, and even greater than, the directions for dealing with snake-bite.

If our legislators so will it, small-pox need not exist at all, and may be absolutely starved and hunted out of the country.

He accepts the very gravest moral responsibilities who, in the face of the evidence we possess, will try, by word or deed, to discredit vaccination.

JOHN SERVICE, L.R.C.S. and L.R.C.P., Edin.
Hospital Ship Faraway, Quarantine Station,
North Head, Sydney.

ADVERTISEMENT OF DIPLOMAS BY AN UNREGISTERED PRACTITIONER.

S. E. HERBERT, M.D.,

L. et Lic. Mid., R.C.P., Edinburgh.

Residence: Menangle-street, Picton,
opposite Protestant Hall.

(To the Editor of the A.M.G.)

SIR,—The above advertisement was cut from the *Campbelltown Herald*. This is the Dr. Herbert who wrote a long letter in your paper some short time back, complaining that the Medical Board of New South Wales would not place him on the Medical Register on the strength of his Philadelphia degree, on which diploma his demand for registration was solely founded. Why does he not ask the Board to register the L. et L. Mid., R.C.P., Edinburgh, which he advertises, if he really possesses these? If he is not entitled to this array of letters, why does he advertise himself as possessing them? If he does not possess them, is there no way to prevent him advertising them? Yours, &c.,
M.D.

Camden, January 18th, 1885.

MEDICAL APPOINTMENTS.

Ash, William Conyngham, L.R.C.S., Irel., appointed Paid Medical Officer to the Newcastle Hospital, N.S.W., for the ensuing twelve months.

Coleman, Alfred, F.R.C.S., Eng., to be Honorary Surgeon to the H Battery of Artillery, New Zealand Volunteer Force.

Cunningham, Peter Hannah, M.B. & Ch.M., Glasg., to be Health Officer for Shire of Majorca, Vic.

Forde-Clark, Harry, L.R.O.P. & R.O.S., Edin., to be Government Medical Officer for the District of Morea, N.S.W.

Forbes, Armitage, L.R.O.P., Edin., L.R.O.S., Irel., to be Government Medical Officer and Public Vaccinator for the Tweed River District, N.S.W.

Gillespie, William, F.R.C.S. & L.R.O.P., Edin., to be Public Vaccinator for Corryong and Tintaldra, Vic.

Hacon, Walter Edward, L.R.O.P., Lond.; M.R.C.S., Eng., appointed Honorary Surgeon to the E Battery of Artillery, New Zealand Volunteer Force.

Jee, Henry Christian, M.R.C.S.E., L.R.O.P., Edin., to be Public Vaccinator for Charlton, Vic.

Jomason, Hermann, M.D., to be a Member of the Medical Board of Victoria.

McKee, James Charles, L.R.O.P. & R.O.S., Edin., to be Health Officer for Borough of Raywood, Vic.

McMash, Arthur William, L.K.Q.C.P., Irel.; L.R.C.S., Irel., to be Government Medical Officer and Vaccinator for the District of Dungog, N.S.W.

Mart, Joseph Bell, L.F.P.S., Glasg.; L.R.O.P., Edin., to be Health Officer for the Shire of Ballan, Vic.

Mayo, George, F.R.C.S., Eng., to be President of the South Australian Medical Board.

Mitchell, James, M.B. & Ch.M., Aberd., to be Government Medical Officer and Vaccinator for District of Narrandera, N.S.W.

Morier, Charles George Drummond, L.R.C.S., Irel.; L.K.Q.C.P., Irel., to be Public Vaccinator for District of Nairne, S.A.

Nickoll, Edward Harvey Bird, L.R.O.P. & R.O.S., Edin., to be Public Vaccinator for Lancofield and Romsey, Vic.

O'Reilly, Walter W. Joseph, M.D. & Ch.M., Dubl., M.R.C.S., Eng., appointed Honorary Physician to the Sydney Hospital.

O'Leary, Morgan Philip, L.K.Q.C.P., Irel.; M.R.C.S., Eng., to be Medical Officer to the Destitute Board for the District of Yankalilla, S.A.

Parry, Lloyd Davenport, L.R.C.S., Edin., to be Government Medical Officer and Vaccinator for the District of Temora, N.S.W.

Souter, John Clement, M.D. & Ch.M., Aberd., to be Government Medical Officer and Vaccinator at Murrumburrah, N.S.W.

Vanzetti, Giulio, M.D., to be Public Vaccinator for the District of Nymagee, N.S.W.

Whitton, Thomas Bain, M.D., L.R.O.S., Edin., appointed Surgeon to the Beeston Hospital, N.Z.

Will, William Johnstone, M.B. & Ch.M., Edin., to be Public Vaccinator for the Dunedin District, N.Z.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Canny, Denis Joseph, M.R.C.S., Eng., 1884; L.R.O.P., Edin., 1884.

Ferguson, Robert, M.B. & Ch.M., Glasg., 1878; M.D., Glasg., 1879.

Diamond, James, M.B. & Ch.M., Glasg., 1879; M.D., Univ. Glasg., 1877.

Fybus, John Alfred, L.R.O.P., Edin., 1878; L.S.A., Lond., 1878; L.R.C.S., Edin., 1878.

Graham, James, M.B. & Ch.M., Edin., 1882.

Mallam, Laurence George, M.B. & Ch.M., Edin., 1884; M.R.C.S., Eng., 1884.

Makins, George Reginald, L.R.O.P. & L.R.O.S., Edin., 1882.

Mitchell, James, M.B. & Ch.M., Aberd., 1884.

Thorp, Robert Crossing, M.D., St. And., 1883; L., 1883, F., 1881, R.O.S., Edin.

Thorp, Charles Gabourel, M.B. & Ch.M., Edin., 1884.

NEW ZEALAND.

Harrison, William Atkinson, M.B. & Ch.M., Edin., 1880.

Nairn, David Mathewson, L. & L. Mid. R.O.P. & R.O.S., Edin.

Brownlee, Joseph John, M.D. & Ch.M. Roy. Univ., Irel., 1883.

Mahon, George Annesley Derville, M. & L. Mid. R.C.S., Eng. & L.S.A., Lond., 1882.

Innes, Francis William, M.B. & Ch.M., Edin., 1881.

QUEENSLAND.

Newton, John Lawrence, M.R.C.S., Eng., 1862; L.S.A., Lond., 1862; L. & L. Mid. R.O.P., Edin., 1868.

Black, James Grant, L. & L. Mid. R.O.P., Edin. & F.P.S., Glasg., 1873; M.B. & Ch.M., Glasg., 1874.

Broom, Arthur Robert, M.R.C.S., Eng., 1882; L. & L. Mid. R.O.P., Edin., 1882.

Edwards, David Richard, M.B. & Ch.M., 1871; M.D., Edin., 1875.

Young, William Edward.

SOUTH AUSTRALIA.

Burton, Charles Frederick, L.S.A., Lond., 1880.

Reid, John, M.B. & Ch.M., Aberd., 1882.

Lloyd, Henry Sanderson, M.B. & Ch.M., Edin., 1882; M.R.C.S., 1882.

Milne, James, M.B. & Ch.M., Edin., 1883.

WESTERN AUSTRALIA.

Jameson, Adam, M.B. & Ch.M., Edin., 1883.

PUBLICATIONS RECEIVED.

Handbook of the Diseases of the Eye and their treatment. By Henry R. Swanzy, A.M., M.B., F.R.C.S.I., Surgeon to the National Eye and Ear Infirmary, and Ophthalmic Surgeon to the Adelaide Hospital, Dublin. Illustrated. London: H. K. Lewis, 1884.

Contributions to the Anatomy and Pathology of the Nervous System, Series III, No. 3. Singular Case of Vertebral Disease. By Richard Mollenhauer, M.D., Physician to the North-Eastern Dispensary.

Report and Minutes of Proceedings of the Australasian Sanitary Conference of Sydney, 1884. Sydney: Th. Richards, Govt. Printer.

Report and Minutes of Proceedings of the Wood Pavement Board. Sydney: Th. Richards, Govt. Printer, 1884.

On Sounding for Gallstones. By George Harley, F.R.S., M.D., F.R.C.P., &c., &c. London: J. and A. Churchill, 1884.

Fifth Annual Report of the State Board of Illinois. By Dr. John H. Rauch, secretary. Springfield, Ill., U.S.A.: H. W. Rokker, 1883.

Practical Recommendations for the Exclusion and Prevention of Asiatic Cholera in North America. By John H. Rauch, M.D. Springfield, Ill., 1884.

The Revival of Ovariectomy, and its influence on Modern Surgery. By Sir Spencer Wells, Bart. London: J. and A. Churchill, 1884.

Health and Home Nursing: Being five lectures delivered at the Dunedin Hospital. By D. Colquhoun, M.D., Lond., M.R.C.P., Lond., M.R.C.S.E., Lecturer on Practice of Medicine, Otago University. Dunedin: Jos. Braithwaite, 1884.

REPORTED MORTALITY FOR THE MONTH OF DECEMBER, 1884.

Cities and Districts.	†Population.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from							
				Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Child-bearing.
N. S. WALES.											
Sydney	103,379	288	138	...	6	4	2	15	30	24	1
Suburbs	120,832	354	219	...	5	1	4	6	47	25	1
NEW ZEALAND.											
Auckland	28,028	33	18	...	...	4	...	...	7	1	...
Christchurch.....	16,337	19	10	...	...	...	2	...	...	...	1
Dunedin	26,176	15	4	...	...	...	...	...	...	4	...
Wellington	22,717	32	11	...	...	...	2	...	1	3	1
QUEENSLAND.											
Brisbane	26,557	40	18	*	...	...	...	...	...	...	...
Suburbs	9,612	41	8	...	...	...	...	...	...	...	...
SOUTH AUSTRALIA.....	318,155	411	210	1	...	7	1	7	82	26	1
Adelaide	42,605	111	49	...	...	1	...	2	18	11	1
TASMANIA.											
Hobart	28,456	44	25	...	...	1	...	...	1	4	...
Launceston.....	17,898	53	24	...	...	2	1	1	...	2	...
Hospitals, Asylums, Gaols, &c. .	1,015	38	...	...	...	...	...	...	...	...	...
Country Districts.....	81,246	70	...	...	...	2	4	...	...	...	...
VICTORIA.											
Melbourne	65,791	102	311	19	...	5	9	9	78	70	12
Suburbs	238,618	574									

* The Official Monthly Report on the Vital Statistics of Brisbane and Suburbs does not show the number of deaths from the various diseases.
† The population of N. S. Wales, Queensland, and Adelaide is that of the census of 1881; New Zealand, South Australia, Tasmania and Victoria show the estimated population at the present date.

METEOROLOGICAL OBSERVATIONS FOR DECEMBER, 1884.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
							Inches			
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E.....	...	97.6	67.1	47.9	29.702	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.....	...	75.5	62.2	51.	...	5.660	19	72	...	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	171.	101.	80.3	61.	29.824	5.06	11	64	N.E.	...
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.....	...	...	...	...	...	...	...	...	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.....	148.	71.	54.7	43.	...	4.080	28	80	...	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.....	...	76.2	57.8	45.5	29.617	3.93	21	78	...	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E. ....	...	75.	60.2	40.	29.677	3.73	20	66	...	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	...	89.3	61.2	43.3	29.684	3.05	14	...	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ...	...	91.	70.4	56.4	29.783	1.23	10	55	N.E.	...
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	145.	70.	58.7	44.3	...	12.459	23	81	...	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

EXTIRPATION OF THE UTERUS FOR MYOMATOUS TUMOUR.

BY E. MATTHEWS OWENS, L.R.C.P., EDIN.,
M.R.C.S., ENG., OF QUEEN STREET, BRIS-
BANE; LATE OF BIRMINGHAM HOSPITAL FOR
WOMEN, AND MIDLAND EYE HOSPITAL.

I CANNOT express too highly my admiration for Dr. Stirling and his mode of operating in the above case, reported in December number of *A. M. Gazette*. It may be interesting to him and your other readers if I give the mode of operating in these cases by my friend, Lawson Tait, who is acknowledged to be, in England, second to none in this particular operation. I myself assisted him in seventeen consecutive successful operations. He, too, believes that it is an operation that will in the future be quite as successful as ovariectomy. You will see, when I have related his mode of operating, how closely Dr. Stirling has followed him, and yet I think the little differences will often tend to success or failure.

Place of Operating.—All abdominal section cases are operated upon in the rooms they are to remain in, which rooms are quite separate from the main wards of the hospital. The rule is, patients occupy the room, they are operated in, five days, and then all being well, they are drafted into main wards, and the rooms they have left being thoroughly cleaned, windows and doors left open, and not occupied by any fresh case for five days, so that each ward has about 80 cases during the year passed through it. These wards are lined with wood, stained and varnished; to give more cubical space, there is no closed place under the roof.

Ventilation.—Besides door, window, and fire-place, each room has ventilating shutters at the eaves of the roof.

Nurse.—A nurse is detailed off to attend solely upon the one case, and she is forbidden to hold any communication with other wards. It has been found that it is not much strain for one nurse to take continuous duty for five days, as she then has a rest, and besides, as a rule, abdominal cases give very little anxiety.

Assistants.—Never more than one beside the administrator of the anæsthetic.

Visitors have to sign a declaration that they have not been near any infectious case or attended any P.M. examination within a specified time.

Anæsthetic.—Always æther, which, as a rule, is given by enveloping the patient's head in a towel and pouring the æther on the towel over the face. The patient is narcotized in bed and carried to the table. The narcotism is always carried on deeply; this is a great point.

The table is a narrow board on trestles, covered with a blanket and macintosh; the advantage of this being that a heavy patient can be carried on the board, which is placed on the bed and the patient slipped off it. The patient is secured to the table by a bandage passing over the thighs, and the hands are also fastened by a bandage going round the wrists, under the back, and round the table. The urine is drawn off by nurse immediately before the operation, and the bowels are well relieved by an enema. The feet of patient towards the window. The patient's pubes are never shaved. Her feet and legs are wrapped in blankets.

Position of Operator, Assistant and Nurses.—The operator on right of the patient, assistant on left, chloroformist at right side of head; two nurses on right hand of assistant. The operator has his instruments on a table to his right hand; all instruments are in little vulcanite trays, twelve, or numerical of twelve, of every instrument, for ease of counting at end of operation. Before wound is finally closed all instruments and sponges are counted, as several cases are recorded where sponges or instruments have been shut up in abdominal cavity. Boiling water is poured over the instruments in the trays, and this I may say is the only disinfectant used. A basin of water is placed on a chair to left of operator, to wash his hands, and under the table a basin with the sponges, which have been most carefully prepared, for more patients have been killed by dirty sponges than mistakes in operating. Either 12, 18, or 24 sponges are used, according to operation; the operator and assistant having well washed their hands and arms, cleaned their nails, turned their shirt sleeves up to shoulder, and protect clothes as best you like. Mr. Tait always wears a blue serge coat, which is washed after every operation. The nurses' duty is to wash the sponges, one taking the dirty sponges in basin from the assistant, and also receiving the cleansed sponges in another basin, so she never touches the sponges with her hands. The sponges are washed in 3 waters before being handed back to second nurse for her to hand to assistant.

The incision in amputation cases, of course, must be of sufficient length to give room for manipulating a solid body, but in simple ovariectomy there was a tendency to get them too long, sacrificing the

after comfort of the patient to facilitate matters for the operator. I called attention to this in *Lancet* of 1883, and from what I hear now, operators are much more careful to limit their incisions as far as possible. Mr. Tait is very careful to control all vessels by applying a Kœberle forceps to every bleeding vessel *before* he opens the peritoneal cavity. He does not use a director to open the peritoneum upon, but pinches it up with forceps and then opens it up with finger, using the finger as a director. I shall now only describe the operation for amputation of the uterus.

Having made the incision of sufficient length, according to the size of the tumour, open the peritoneum, sweep the hand round the tumour to see that it is free from adhesions—which I may say are very rare in this disease—Mr. Tait bores a corkscrew into the tumour, and no one can tell the comfort this gives an operator, for a myomatous tumour is a most slippery article, and from being most unmanageable it becomes quite manageable with a corkscrew buried in it. This is quite an original thought of Mr. Tait. Having drawn the tumour outside the abdomen, sponges are packed all round it in the abdomen. These are useful not only to catch the blood, but also to keep back the intestines, which are often most obtrusive. After the tumour is drawn out, it is carefully examined to see position of parts, the bladder more especially. A Flocks' ecraseur is passed round base of the tumour, but instead of wire a rope is used, which has been carefully soaked to contract it—I say base of tumour advisedly, because generally there is little or no pedicle. The ecraseur rope is passed below broad ligament and ovaries. This is now tightened up as far as possible, and *below* the rope ligature a copper wire, silvered, is passed, fastened and gradually tightened by Tait's clamp, which is far and away the best clamp I have seen. It is difficult to describe, but at some medical meeting I shall at some future time be glad to shew it to those who are interested. The tumour now may be said to be grasped by two ligatures, and which are tightened one after the other. As soon as the operator is sure that the copper wire has got the tumour under control, he proceeds rapidly to amputate above rope ligature, taking care to keep all the blood possible out of the abdominal cavity. As soon as the tumour is removed with ovaries and broad ligament, then becomes evident the use of two ligatures, for if there is any oozing from the stump, tighten the wire ligature and it will soon be seen whether the wire controls it, which if it does, you may make it fast and slack the rope, and if all is right cut away the rope. But what a comfort the rope is to fall back upon should the wire break as it is being tightened, and which I saw once happen to Dr. Savage.

I shall never forget the anxiety of those few minutes, for he had no rope to fall back upon. The stump is trimmed and brought to lower end of wound, held there by assistant, and the "toilet" of the peritoneum is done; in other words the abdominal cavity is most thoroughly cleansed, not only by sponging, but by pouring in water and swilling it out after it has been well dried by sponges. The edges of the wound are brought together with china silk sutures, going through skin, muscle, and peritoneum, and above the stump is placed a glass drainage tube which is made to go well down into Douglass' pouch. The peritoneum up to a certain point is the best absorbent gland in the body, but beyond that point it is the most intolerant. The drainage tube is carefully emptied by a sucker every 2, 4, or 6 hours, according to amount of oozing. The stump has placed on it some solid perchloride of iron, which rapidly dries it up; little pieces of lint are tucked in around the stump to prevent the iron getting to skin or wound. A binder only put on. The patient is carried to bed, hot water bottles to feet, which are wrapped in blankets. It is very rare to find any sedative required. Should there be much collapse, an enema of beef tea and champagne is administered. The after treatment is nothing but iced water for 24 hours, after that a little gruel. 3rd day, broth and custard pudding. 4th day, fish. 5th day, chop, &c., if there should be any distension, passing a long tube up to sigmoid flexure will generally relieve it, as there is spasm of anus which will not allow flatus to pass. Enemas are given as required, medicine is rarely or ever given.

Remarks on Dr. Stirling's case.—I feel sure Dr. Stirling will forgive me if I make a few remarks on his case and what he will do well to avoid in the next operation he may have.

Antiseptics.—I think it has been very well proved that Listerism has very little to do with abdominal section cases getting well. At Samaritan Hospital, Mr. Knowsley Thornton carries it out most rigidly, with spray, gauze, &c., &c. On the other hand, Dr. Bantock does nothing of the kind. They operate case for case and their records are equally good, and neither does Mr. Thornton's cases recover more rapidly than Dr. Bantock's. I would not for one moment decry Listerism, for it has taught us cleanliness, and I also think that were I going to have a thigh amputated, or knee joint opened, I would prefer antiseptics used, for we must look upon the flaps as bruised surfaces, for however clean a cut is, it is bruised, and therefore liable to slough; but opening the abdomen all the cut surface is the section, and I am not sure as regards the peritoneum whether the spray is not a positive irritant. Mr. Lawson Tait never uses antiseptics, and while I

was associated with him he did some 280 abdominal cases, with only about 15 deaths, and I can safely say that not one of those could have been prevented by all the antiseptics in the world.

Putting ligature round the broad ligament and ovaries.—This was unnecessary, for the wire ligature should have gone below all; it was more than unnecessary, it was proved a positive source of danger, as it got loose and came away with discharge; it might have become a nucleus of grave trouble.

Preventing protrusion of intestines by napkins.—Sponges are much better, for there is always danger of some fibres of the napkin becoming detached and adhering to the bowels and setting up irritation. Dr. Stirling recognises the danger of chloride of zinc to the stump; he will be quite satisfied with solid perchloride of iron.

Omission of drainage.—Not draining at time of operation was the greatest source of danger of the whole operation, and Dr. Stirling is to be congratulated on having corrected it four days after the operation. His anxiety would have been much lessened if he had inserted a glass tube at time of operation, for I can only reiterate what a splendid servant the peritoneum is up to a certain point, beyond that it becomes most refractory.

If Dr. Stirling has not seen Tait's clamp, he will be much pleased with it, as it is much safer than Koeberle's *serre naud*. I should be glad to know what thickness the wire that broke was, for in every case that I have witnessed, but one, copper wire silvered has acted most perfectly, and the one failure was caused by cutting with screw. In a case of Dr. Savage's too much force was used. Copper wire is better than platinum.

I cannot conclude these remarks without again congratulating Dr. Stirling on his brilliant case, and I hope he will pardon my remarks.

BACILLUS SUBTILIS IN ENTERIC FEVER.

By JOHN REID, M.A., M.B. ET CH.M., ABERD.,
OF ST. GERMEIN, SOUTH AUSTRALIA.

BACILLUS subtilis having been announced by Dr. Cheyne in his communications to the *B. M. Journal*, I ask you to publish the following notes in the *Gazette*.

I removed the ileum from a patient who died in the evening of the previous day; there was slight hypostatic lividity, bowels were full of gases, but no signs of decomposition. The contents were

washed out by a solution of carbolic acid, and then a small portion of an ulcer (mucous membrane only) was placed in a sterilised solution of gelatine, in a test tube plugged with cotton wool. There developed a micrococcus colony of a light sky blue colour in rings.

A little of this was injected into the ear of a mouse, and the remainder of the fluid was given it to eat, along with lard. On the day following it appeared weakly and apathetic, more so on the second day, and on the third I found it dead. On examination I found Peyer's patches inflamed, and for the purpose of cultivation I removed part, but did not wash it. My gelatine solution was scarcely solid, so that the intestine sank. In my solution, bacillus subtilis (Prazowski, *Bacterien Arten*, 1880, p. 56) was developed. I removed the intestine by melting the gelatine (solid at the bottom of the tube) and placed it in a sterilised gelatine solution, but I did not wash it. The result of cultivation showed the light sky blue rings, but also the bacillus subtilis cultivation. Want of mice and a pure solution prevented the extending of my observations. In the human Peyer I noticed micrococci chiefly in the cells (leucocytes), the same also in the mouse after staining with magenta, but in a part of the mouse (not washed) I also observed bacillus subtilis, but none in the leucocytes. I am not aware of the communication of enteric fever by direct inoculation, hence a confirmation of this will be valuable and interesting.

In the case of the patient I attended, all excreta were burnt as the most perfect mode of disinfecting, more especially as wells varying in depth are in use here. A closet with a pan (built of brick, say), containing moveable iron lid and bottom, and having a fireplace below, would probably soon rid these colonies of the scourge. The gases evolved during the heating process could be passed through the fire, and when the fæces were dry, the bottom of the pan could be removed and the fæces burnt. Only ashes would be left, perhaps not valuable, yet perfectly harmless. Cremation of bodies would tend in the same direction, but many prejudices will have to be overcome and difficulties surmounted before that becomes general.

In the *Gazette* I note death rate in South Australia for October and November, 1884, and if we calculate 10% as a fair average mortality, there were nearly 1 in 10,000 affected per month, or, in betting language, 1 for, and 9,999 (per month) against the chance of being affected by enteric fever, or 1 for, and 99,999 against, the chance of dying from it, per month—not a large chance to be sure, but, if *remediable*, much too large, and perhaps quite large enough if other chances of death are added on.

THREE CASES OF OVARIOTOMY.

By J. O. CLOSS, M.B. ET C.M., ED., INVERCARGILL, NEW ZEALAND.

I FEEL sure that in publishing the results of the three following cases, which have lately come under my care, I shall be doing a duty to the profession and adding to the statistics of an operation which in the Australian colonies, if not elsewhere, is still upon its trial.

By this I do not mean Ovariectomy in the usual acceptation of the term, but what some have been pleased to call Oöphorectomy, Batty's operations, and such like. I prefer, however, to agree with Mr. Lawson Tait, who says that when he removes an ovary, he calls the operation Ovariectomy.

CASE A.—Age 38 years, married, nullipara. I was called last March, 1884, to see this patient, and found her suffering from severe pelvic pains, which no position of the body could give relief. She also suffered from occasional attacks of shivering, headache and vomiting, while constipation was a constant accompaniment. She informed me that she had been married eight years, never was pregnant, and for fully that time she had suffered more or less pain, but for the last five years it was getting gradually worse and beyond endurance. As is the usual history of such cases, she had been repeatedly under medical treatment without any relief. She had worn pessaries, had been treated for ulceration of the womb, and had rested as much as possible.

She dreaded her menstrual periods, as then she suffered most; the flow was free and copious, lasting generally from six to nine days. Her locomotion was characteristic, bending the body forward and slowly dragging one leg after the other, while any action that shook her more than usual gave her excruciating pain. Coitus could not be suffered at all. She had a worn, haggard, melancholic expression.

On examination, the vagina, the os, and cervix uteri were normal.

The uterus could be made out distinctly by bimanual examination; it was slightly retroflexed and rather large for a nullipara. The sound passed fully the 2½ in. index, and gave her some pain.

By the recto vaginal examination there could be felt in the mesial plane and posterior to the uterus two small bodies, one distinctly, the other not so, both exquisitely tender to the touch; these were diagnosed and afterwards proved to be dislocated ovaries.

Considering the state of matters in this patient, I was convinced that she suffered from chronic

disease of the ovaries with their reflex phenomena in addition to their misplacement.

I was equally convinced that nothing but operative treatment—namely, removal of both ovaries, would be likely to do her the slightest good. My consultant, however, was not inclined to run the risk of an operation, so she was put upon the bromide treatment and ordered to bed for a month with a Hodge's pessary, an ovarian one not being procurable. When in bed she complained very much of pain in her back and thighs. On the third day, vomiting and violent retching set in, necessitating the removal of the pessary, which was not again inserted. The vomiting and retching lasted for the next five days, nothing being able to check it save hypodermic injections of morphia. During this time she was nourished by beef tea and such like enemata, but was so prostrated that she was unable to leave her bed for the next three weeks. After this, matters were not improved. The kind and dangers of an operation were fully explained to her, but she preferred to run the risk of death rather than suffer her present misery.

Accordingly, after everything was prepared, I removed both ovaries, on the 17th June, by abdominal section. Strict antiseptic precautions were observed.

After opening into the peritoneal cavity, through an incision about 2½ or 3 in. long, both ovaries were felt in the middle line and behind the uterus; the nearest to hand proved to be the left; it was bound down by slight adhesions which easily gave way and allowed its elevation to the surface of the wound.

The pedicle was transfixed with a double carbolized silk ligature, about ¼-inch from the hilus. The ovary was removed and the pedicle dropped into the peritoneal cavity, when sure that all bleeding had ceased.

The other ovary, the right, was treated in a similar manner, but the adhesions in this case were very strong, and its elevation was a matter of difficulty. After the peritoneal toilet, the wound was closed in the usual manner with silk sutures, and the usual antiseptic carbolized gauze and protective were used for dressings. The patient stood the operation well, and made an uninterrupted recovery, leaving her bed on the twentieth day from date of operation. The wound healed by first intention, and on the fifth and sixth days the stitches were removed.

The only thing worth recording is, that she suffered a good deal from sickness, which was somewhat relieved by ice and hypodermic injections of morphia. She began to menstruate on the third day from date of operation, which lasted four days.

Since the operation she has never had the slightest recurrence of pain or menstruation. Eight weeks after she was moving about quite freely, could undertake a journey of 139 miles by train in one day without feeling any bad effects. She has steadily and gradually improved both mentally and physically, and now, eight months after operation, is enjoying excellent health and freedom of limb.

Both ovaries were congested, enlarged and cystic. The fibrous tissue was in abundance, very much resembling hypertrophic cirrhosis of the liver.

CASE B.—Age 39, married, pluripara. On the 12th last July, this patient called at my surgery; she presented a very miserable appearance—thin, sallow, careworn and melancholic. She complained of a constant dull aching pain at the bottom of the pelvis, with occasional acute exacerbations, which she described as most terrible, passing down her thighs and round her loins, and of such a severe nature as at times to prevent her from standing or walking at periods of menstruation. It was so bad as to confine her to her bed for several days.

Menstruation was very irregular, coming on every two or three weeks, and lasting generally nine days.

She had suffered principally since the birth of her last child, about four years ago. She then had a very hard labour. Her pains were now becoming unbearable, and if nothing could be done she wished for death as a relief.

She told me the only position which gave her temporary relief was the gum pectoral one.

When in England, and previous to her marriage, she was frequently in hospital, suffering from abscesses in the neck and general breakdown of constitution, and was for some time an in-patient of the Samaritan hospital. She presented a well marked strumous diathesis.

On examination per vaginam, the os and cervix uteri were normal; pressure towards the fornices gave her such pain as to cause her to scream out. The uterus was slightly retroflexed. The passage of the sound gave her considerable pain, and I considered there was some slight endometritis. The recto vaginal examination revealed a few small external hæmorrhoids, and here I may add that she suffered from constipation with occasional reactionary diarrhoea. The finger when pressed home in the rectum gave her more pain than the one in the vagina.

Posterior to the uterus there could be felt two small bodies, very tender to the touch—one was so very small and so indistinctly made out, while the other was of such an irregular shape that their true diagnosis was a matter of difficulty. The uterus moved quite independently from them,

both with sound and vulsellum. The ovaries could not be felt in normal situ. Taking everything into consideration in this case—that she had been for years under medical treatment without relief, that she suffered such heavy losses every fortnight or three weeks, the constant pain and mental misery that was her ever accompaniment night and day, the general broken down state of her constitution—all went to convince me that the prima cause of her misery was diseased ovaries, letting the question of their misplacement remain *sub judice*.

I told the patient what I thought of her condition, and that it would probably come to operative measures in the end. She thought so herself, as she said everything had been tried without any benefit.

I ordered perfect rest for a month, put her on the usual blistering and bromide treatment, and instructed her how to use the glycerine plug.

A fortnight later I had a letter from her, stating that she had done all I told her and that she was no better, and that from domestic circumstances it was quite impossible to give herself any longer the perfect rest I ordered. After this I did not see the patient for several weeks; in the interval she had come into the hospital for treatment, which she left, and I was asked to do something for her relief. After consultation on her case, it was decided that both ovaries should be removed. Accordingly, on the 6th September, I removed them by abdominal section, through an incision about 2½ to 3 in. long. The operation was performed without the antiseptic spray.

The irregular shaped bodies previously mentioned proved to be the altered ovaries. The left was bound down to the broad ligament and fallopian tube, the whole forming a very irregular and gangrenous looking mass. The ovary and greater part of the fallopian tube was removed; the method adopted being the same as in the previous case. During the process of extraction, a large superficial cyst burst, which, at the moment, I thought was an abscess. The right ovary was also removed; it was bound down by very strong adhesions, rendering its elevation a matter of great difficulty, although assisted by the fingers in the vagina. The pedicle being ligatured and ovary removed there was smart hæmorrhage from some torn vessels of the broad ligament, and which could only be commanded by enlarging the abdominal incision downwards about an inch.

The rest of the operation was carried out in the usual manner, but when the abdominal wound was ready for closing, a small sponge was missing; a good deal of time was lost in looking for this about the furniture of the room, and it was only on the third search amongst the intestines that it was discovered in a fold of the

ileum, to the right of the uterus; it had been inserted in the earlier part of the operation and forgotten.

After all was done the patient was very much exhausted; stimulants were given, which answered the purpose. She rested well for some hours, then sickness came on; this left her on the following day, and from that time she made a rapid recovery, leaving her bed on the 13th day from that of operation.

The abdominal wound gave no trouble. She was now entirely free of the old pain, was able to stand erect and reach to her full extent above her head. The bowels moved regularly and without pain. She began to go out and move about freely in spite of all advice to remain quiet. She next went on a visit to a friend, a short distance from town, and while there disregarded the advice to rest herself. Shortly after this she journeyed home, a distance of some 20 miles, by train; when there a few days, circumstances forced the family to remove to another town, some 50 miles by rail. I happened to see her when passing through, she was then menstruating and complained of some pain, but nothing like what she was accustomed to suffer. She was no sooner comfortably settled in one house than she had to move to a second, and during all these shiftings about she was more or less upon her feet, and assisting to some extent, at least, in the general packing up of house furniture. All this moving about was done within six weeks from day of operation. Since then she has menstruated several times, and on each occasion it has been less in quantity than before. The last time I saw the patient was on the 2nd January, she was then very well, but resting as much as possible, and news has just been communicated to me from the medical gentleman of the town in which she resides, and who has been good enough occasionally to give her some advice, that she is now in good health, that her menstruation is merely a show, accompanied with very little pain, while in the interval she is entirely free from it. I have no doubt but that when the menopause is complete the patient will enjoy freedom from either.

Both ovaries were cystic, the left specially so, and as I have said, matted together with fallopian tube and broad ligament. The right was very much atrophied and cirrhotic, and surrounded by extensive adhesions.

CASE C.—A DERMOID CYST OF THE RIGHT OVARY.—This patient consulted me about the middle of last August; age 29 years, married, had four children, no miscarriages. She complained that she had suffered from sickness and vomiting for nearly twelve months, which, as a rule, came on every morning, simulating for some time that of pregnancy; indeed, although she was

regular every month in her menstruation, a circumstance which did not happen when she was pregnant at other times, she was quite convinced that she was again in that state, and even affirmed that she felt life. As time passed she began to think there must be something wrong, and watched her condition more carefully. Sickness and vomiting in the morning continued, and menstruation regular. She could now feel a lump in the right iliac region, movable with the position of the body. About the same time she began to feel pain in the same region so as to render walking at times difficult, also that the right leg began to swell.

On bimanual examination there was felt a hard round tumour, about the size of a large orange, to the right side of the uterus, which latter was pushed slightly forwards and to the left.

Something like a pedicle was made out, but it was difficult to say whether it was a long pedicle of a fibroid from the side of the uterus, or the pedicle of an ovarian growth. The contra indications of a fibroid uteri were so great that that might be excluded.

I therefore advised the patient to undergo operation for its removal. This she readily consented to, and I performed Ovariectomy on the 4th of last October.

The operation was conducted without the anti-septic spray.

After opening into the peritoneal cavity, in the usual manner, by an incision about 4in. long, I endeavoured to remove the growth. There were a few small adhesions to the broad ligament and side of the uterus, but none of a serious kind. The tumour was elevated and removed as I did the ovaries in the previous cases. The left ovary appeared to be normal. The remaining steps of the operation were carried out as usual, and the patient placed in bed. She stood the operation well, during which she was frequently sick.

After resting quietly for a few hours, sickness and vomiting set in, and proved one of the most distressing complications for the next six days. I have no doubt but that this severe and lengthened attack had much to do with the previous habitual sickness she was so constantly suffering from. On the second day I examined the wound, it looked pretty healthy, the deep dressing unsoiled. On the following day I examined it again, there was no discharge, but a large rim of inflammation was around it. This I attributed to the violent retching and the great strain put upon the stitches. On the following day, 4th from operation, Temp. 104.2, the highest recorded; patient semi-delirious, abdomen tense and tympanitic, vomiting very severe. I judged septicity to be the cause of this, and proceeded at once to

remove the two lower stitches, when there followed a free discharge of pus. I inserted a five-inch drainage tube and irrigated the cavity with a weak solution of carbolic acid, and applied a new dressing of compressed carbolized wool; gave a hypodermic injection of morphia, and an enema of beef tea containing gr. 10 of sulphate of quinine, and ʒi of dilute hydrobromic acid. This gave her good rest for a couple of hours, after which she seemed more composed. In the evening the Temp. had descended to 103.4°F . The previous enema was repeated, and later on in the evening another hypodermic injection of morphia; of this she could stand a considerable amount, as it was the only thing that seemed to check the sickness. She slept tolerably well at intervals, and in the morning the Temp. was 102°F , P. 118. Sickness and vomiting still continued, but was less severe. She could at intervals retain on the stomach a spoonful of chicken soup, with 10 m of the *Ol. terebinth.* in mucilage and syrup. A long flexible stomach tube was passed occasionally, for a few minutes at a time, per rectum, to assist the escape of flatus, which was very troublesome at times. The abdomen remained pretty tense, exhibiting a large area of hardness, very tender to the touch. The wound discharged freely, and was dressed two or three times daily. She now began to improve with marked rapidity. Her exhausted state, and more especially the condition of the wound, confined her to her bed for a longer period than otherwise would have been. She was able to sit up at the end of the third week, and left her room about a month from date of operation. At the end of the fifth week she menstruated normally. Shortly after this she went home. Since then she has presented herself twice. She enjoys excellent health, can walk freely or ride on horseback without suffering any inconvenience.

The cyst consisted of a thin envelope, a rind of sebaceous matter, about a quarter of an inch thick, and in the centre a large lock of black hair. I have endeavoured to lay these cases faithfully, and as fully as possible before the profession, allowing each to draw his own conclusions. The cases speak for themselves. In the case of the dermoid cyst there can be no two opinions as to the propriety of operation, but in the other two cases there may be some that have their doubts, preferring passive treatment and long suffering, or may be worse, to anything so bold or hazardous as Ovariectomy. I am fully aware that if the patient is in the early stages of ovaritis, or even if the disease has to some extent passed into the chronic condition, other than operative measures should be tried, and perhaps with some good effect; but when the patient has been subjected to years of

suffering, and when the ovaries have undergone the usual pathological changes, consequent on long chronic inflammation, we know, that as yet, there is no treatment other than complete removal of the diseased organs likely to result in the slightest benefit—and the wonder is that this operation has not been performed more frequently.

In conclusion, I have to thank Drs. Whitton and McPherson for their kind and able assistance.

A CASE OF RARE SPONTANEOUS FRACTURE OF THE FEMUR, BELOW THE TROCHANTERS.

By LOUIS FITZ PATRICK, L.R.C.P. et M.R.C.S., EDIN.; MEDICAL OFFICER QUEANBEYAN DISTRICT HOSPITAL, N.S.W.

IN the November number of the *A.M.G.*, Mr. Beeston, of Newcastle, has placed on record three unusual cases of fracture. I also feel encouraged to give a short account of a very peculiar and rare muscular fracture of the femur, occurring just below the trochanters, which has recently come under my care.

History.—George Shepherd, æt. 32, 5 ft. 8 in., strong build, healthy appearance; father and mother living, the former æt. 80, the latter 65; three brothers and four sisters living—healthy. One brother died in infancy. He has never had syphilis; neither had his parents to best of his belief. He has served twelve years in the Royal Regiment of Artillery; some of these were passed in the East Indies. While in India he suffered from a few attacks of jungle fever. He also, while abroad, received a contused wound on the back, caused by a fall from a young horse. From the latter he was four days confined in the Poona Hospital, after which he was discharged and returned to duty quite well. Never had any other sickness or injury, with the exception of gonorrhœa (simple). Has been in the colonies six years. Up to the time of his receiving the accident which gives a title to this paper he had been employed as a navy on Messrs. Johnson's railway works near Bungendore. He was a shovelman, and his duties were light, viz., filling the drays with rubbish from the cuttings. During the forenoon of the day, upon which he received his accident, he occasionally noticed a sharp pain shooting from the sole of his foot up into the hip. He paid little attention to it, only stopping "to rub the leg now and then." Suddenly, while in the act of throwing a shovelful of rubbish into a cart, he felt something give, and immediately fell

to the ground. On his mates raising him he was heard to exclaim, "Look, lads! my toes have gone round where my heels should be." He was placed in a buggy and driven to my house, a distance of twelve miles. On examination I noticed that his countenance was cheerful, indicating all absence of pain; indeed, he confessed that he felt none whatever. On removing his clothes and investigating the seat of injury all doubts as to diagnosis, however, were set at rest. The skin was perfectly natural in appearance, no bruise or discoloration of any sort being present. But the head and neck of the femur protruded as a hard tumour, which, on pressure, could be pushed down into its place, but immediately rebounded on removing the pressure through the powerful influence of the psoæ and iliac muscles. Their irritated fibres imparted to the tumour a constant throbbing or jumping sensation similar to that felt by placing the hand over the heart's apex. The shaft of the bone was drawn upwards, backwards, and outwards. This Mr. Butcher (the famous Dublin surgeon) attributes to the action of the hamstring muscles. This portion of the bone could also be brought into the normal position by moderate pressure and extension, but on removing same the leg shortened and the bone again protruded. I felt little hesitation in pronouncing the case to be one of "muscular fracture of the femur immediately below the trochanters."

I consider the case especially interesting from the following points: There is no history of previous injury or disease, either on the part of the patient or his parents; he received no blow, neither did he give himself any sudden or abrupt jerk, or make a false step; his bones throughout the body are hard and well shaped; teeth are regular, sound, and well enamelled; complexion clear and eyes bright. The case is also interesting from the fact that, although surgical history relates that the olecranon, os-calcis, and os-patella have frequently been the seats of spontaneous muscular fracture, the long bones have seldom been the subjects of such an accident. We know, on the authority of Taylor, that the os-humeri of a healthy man has been broken by the muscular exertion of throwing a cricket ball. Mr. May reports the case of a young lady who fractured the neck of the scapula when throwing a necklace over her head (vide *Med. Gaz.* 1842.) The only case on record similar to the subject of this paper is mentioned by Taylor in his work on "Jurisprudence." The case was treated in Guy's Hospital, London, in 1846. After describing the injury, Mr. Taylor says—"The case is remarkable, inasmuch as spontaneous fractures of the thigh bones are very rare, especially as the man had not suffered from any of those diseases

which cause preternatural fragility. The italics are mine.

The patient remained only twelve weeks and one day in hospital. The long splint of Lister was not used. I object to it as causing great pain and inconvenience to the wearer, and producing, in many instances, a stiff and troublesome knee. Moderate flexion at the knee is most desirable. I used a splint somewhat after the pattern of Mr. Nathan Smith's, of New York. The thigh was first washed with carbolic lotion, and then firmly bandaged in lint. A rod of iron wire was run along the anterior surface, from the pelvis to the foot, being bent to a suitable angle at the knee. All was then enveloped in porous plastic felt, first softened in boiling water and then firmly moulded round the limb. A weight of 9 lb. was hung from the foot throughout, and the leg supported on soft pillows. Since leaving hospital he has followed the occupation of an ordinary labourer, and has been under my daily observation. I may add that, with the exception of less than a quarter of an inch extra length to heel of foot, he requires no artificial help.

I hope my kind readers will agree that, notwithstanding the awkward position of the fracture, the results are fairly satisfactory.

CASE OF RENAL CALCULUS COMPLICATED WITH ACUTE PERITONITIS.

By W. M'MURRAY, M.D., SURGEON TO WALGETT HOSPITAL, N.S.W.

P. H.—, æt. 56, a storekeeper, sent for me early on November 17th. On my arrival I found him in bed, and he then stated the following history:—

He retired to rest on the night previous in his usual health; about 6.30 a.m. he was rising out of bed when he was seized with a violent pain in the right side, which was increasing in intensity, accompanied by severe vomiting. He had never suffered in same manner before, and could attribute it to no cause.

On examination I found him sweating profusely, he had pain rising to intense agony in the right lumbar region; it extended along the course of the ureter down to the bladder, and along the spermatic cord, the right testicle being retracted. Sometimes he passed into a state of fainting.

The bladder was irritable, urine smoky, strongly acid in reaction, containing no albumen, diminished in quantity. His temperature 99·2. Bowels had acted previous day.

Having diagnosed nephritic colic, I applied locally linseed poultices sprinkled with Tinct. opii. I gave him a hypodermic injection of morphia $\frac{1}{4}$ gr., and ordered also 20m. of liq. morphia hydro. every 3rd hour in syrup and water. Diet, soda water and milk. Dec. Hordei and other dilutents.

At 12 o'clock I saw him again. Pain still severe. Sweating and vomiting profusely. Gave him hypodermically morphia $\frac{1}{4}$ gr., after which he was temporarily relieved. At 11 p.m. pain still severe, vomiting diminished, he was restless, and I administered another hypodermic injection of morphia $\frac{1}{4}$ gr.

November 18. Early this morning I visited him, he had passed a fair night, but at 6.30 the pain and vomiting had returned. Temp. 100·6; urine smoky, strongly acid. Ordered sinapism over epigastrium to relieve the retching; continued soda water and milk equal parts. Administered a hypodermic injection of morphia $\frac{1}{4}$ gr. Condition at 12 much the same; ordered him a simple enema, after which his bowels acted freely. At 11.30 p.m. complained of the pain more in abdomen, T. 102°. Has ceased vomiting.

November 19. Passed a restless night. Temp. 103·6. Pulse hard and wiry. Malar blush. Pain in right lumbar region absent; now situated over entire abdomen, which is markedly tympanitic and painful on pressure. Hippocratic aspect. Tongue dry and cracked. Position in a state of flexion. Urine has lost its smoky tint, and is now febrile in character. I stopped his morphia mixture and put him on pills containing $\frac{1}{4}$ gr. opii and 2grs. quina sulph., one every 3rd hour; also a hypodermic injection of morphia $\frac{1}{4}$ gr. Brandy, beef tea, chicken jelly, soda water, and milk, &c.

Locally, turpentine stupes every five minutes for half an hour night and morning.

In the evening his aspect was better. Tongue had responded to the stimulant, being moist. Urine in abundance, and not so markedly febrile. Temp. 102.

November 20. Passed a good night. Temp. 100·6. Pain not so severe. No vomiting. During the day passed flatus per ani.

November 21. Temp. 99·8. Bowels acted. No pain. Tympany diminished. Pills to be taken every 5 hours.

November 22. Continued to progress satisfactorily. Pulse and temperature normal. Pills stopped, ordered a vegetable tonic, and spoon food.

November 24. Convalescent.

THREE CASES OF SERIOUS INJURY TO THE SPINE TREATED BY THE PLASTER OF PARIS JACKET.

BY WILLIAM S. BYRNE, M.B. ET M.CH., T.C.,
DUBL., OF BRISBANE, QUEENSLAND, LATE
MEDICAL SUPERINTENDENT PRINCE ALFRED
HOSPITAL, SYDNEY.

I AM induced to publish the following three cases for the ensuing reasons: That severe accidents to the spine are so generally fatal; that the treatment of such cases, as a rule, resolves itself into treating complications and sequelæ, such as bed-sores, chronic cystitis, etc.; that I have seen many cases of spinal fracture always followed by death; and that by the above method of treatment I have reason to believe three consecutive cases of serious spinal injury were benefitted to an incalculable extent.

Leoline J., aged 29 years, the son of a clergyman in England, an engineer engaged in gold mining in New South Wales, was admitted as a private patient into the Prince Alfred Hospital, under the care of Mr. Goode, in the beginning of 1888. It appeared that about six months previously he was beneath a trolley which slipped off a railway line, but by strenuous efforts he prevented it, by means of his arms and shoulders, for about half a minute, till help came. He assured me that the weight he sustained was not under half a ton, and had he let go the trolley he should have been crushed against a bank, and probably killed. On help coming, he felt "something" go in his back, and he became insensible. On recovering consciousness, in about half-an-hour, he was assisted home, a distance of about a quarter of a mile, when he again became insensible, and on recovering he found himself paralysed from the seat of injury (about the dorso-lumbar articulation) down. He remained in this state for about a fortnight, when he began to mend, feeling and motion gradually returning to his limbs, and in a few weeks, though "weak in his back," he went for a ride of some miles, but on his return he was again seized with the paraplegia. He remained in this state for about three months, and as he was not deriving any benefit from treatment was advised to become a private patient at the Prince Alfred Hospital.

On admission his state was as follows:—He was well nourished; there was no wasting appetite, variable—as a rule, poor; bowels generally confined, daily catheterisation necessary, and complete

paralysis of the lower half of the body. There was no displacement of the spine discernible, and the vertebrae seemed to be all in position. The usual treatment of such cases was adopted—electricity, strychnine, belladonna, &c., for about six weeks, without any benefit whatever. During this period he was five or six times attacked with a peculiar kind of tetanic spasm of the spinal muscles, tonic in its character, lasting for from half an hour to an hour, accompanied by agonizing pain. Hypodermic injections of morphia seemed to give but slight relief, and latterly were abandoned. Strange to say, the spasms occurred quite suddenly, without warning of any kind, the nurse having found him several times on the floor, being attracted by his moaning. Once, while having his tea, he was attacked in this manner, and had not time to ring his bell. The spinal muscles at this time would be intensely contracted, curving his back round and as hard as it is possible to conceive. One day, while having some conversation with me, he urged the advisability of some support to his back—as he said himself, he wanted “something to keep me together.” At this time, in fact all through the case, the diagnosis was very obscure, the general idea being that chronic inflammatory destruction of the cord itself was the cause of his symptoms. After consultation with Mr. Goode, it was decided to apply Sayre’s Jacket, and the process having been explained to Mr. J., I, the following morning, proceeded to apply it. I had only partially swung him and applied two rolls of the bandage when he fainted, and I was compelled to relinquish the attempt at once. Brandy and ammonia restored him, and, though very weak, the operation did not do him any harm. This jacket, I need hardly say, was not a success, and had to be removed on the second or third day. I was not inclined to risk swinging him again, but he begged so hard, feeling so confident of success. I placed him under the tripod again in a week’s time, and to my surprise he stood the operation manfully. This jacket was a success, and, within a week, there were visible signs of improvement. Sensation began to return in the limbs, slight motion to appear, and his general condition to improve. From this time forth he gradually got better, until six weeks from the application of the first jacket he was up and walking about, and left hospital still wearing his jacket, with instructions to come back every fortnight. He reappeared the first fortnight, and then, in spite of advice, he removed it himself, and would not have another applied. He placed some inefficient support on instead (a wooden razor strop, I believe), and in three days he had a return of the spasm in his back. After some days I again saw him, and, as

the attacks had increased in frequency, I advised the application of a Sayre again, which was done; but, notwithstanding, the spasms continued. By a mistake, in my absence, he got a hypodermic injection of morphia—a grain and a half in the space of an hour, which proved fatal.

Post Mortem, twelve hours after death.—All the organs were found healthy. A slight amount of meningeal fluid at the base. The third lumbar vertebra was partially dislocated over the fourth, compressing the spinal cord at that point.

I have described this interesting case at length, as the results of treatment were so verified by the necropsy. Had the case been simply medicinally treated, I am sure a permanent paraplegia would have been the result, and had the patient attended to instructions, the case would have terminated differently. I am not aware that this condition, called spondylo-listhesis, has been recorded as occurring in a man before.

Some three months after this, a man was admitted into the general ward of the Prince Alfred Hospital, under the care of Mr. Fortescue, suffering from fracture of the spine. The fracture was undoubted, and was accompanied by the usual symptoms—retention of urine, complete paraplegia, &c. With Mr. Fortescue’s consent I swung him in Sayre’s apparatus, and applied the jacket ten days after the accident. He stood the operation fairly well, and gradually became quite well. He was discharged in about six months, being then able to walk well with the aid of a stick, and still wearing his jacket.

The next case occurred in my practice in Maryborough, on June 1st, 1884. Walter Scott, aged about 35, a carpenter, fell from a height of about twenty-five feet, on the sacral region, and sustained a fracture of his spine about the dorso lumbar articulation. The usual concomitants of such an injury were present. A week after the injury a bed-sore began to appear on the gluteal region, and I determined to swing him as soon as possible. In a few days, as the sore looked red and inflamed, and although he was in a very weak state, I applied the jacket. When swinging he had an epileptic fit, and I had to take him down with an imperfect jacket applied, but in a week applied another successfully. The bed-sore improved and never troubled him again. Motion and sensation returned to the limbs, the urinary functions resumed their action, and he has gradually improved. He suffered very much from chronic cystitis, but I am happy to say it has all disappeared now.

When I last saw him, five months after the injury, he was able to walk about with a pair of crutches, and I have no doubt that in a little while he will be able to dispense with those.

CASE OF THIGH AMPUTATION.

By GASPARO SPELLINI, M.D. ET CH.D., PAVIA;
MEDICAL OFFICER TO MAYTOWN HOSPITAL,
NORTHERN QUEENSLAND.

ON the third of last January, I performed, in the Maytown Hospital, an amputation of the right thigh. The subject was a black boy of about twelve years of age, belonging to Mr. McLean's station. He had got his right leg broken one month before by falling from a horse, and not having abstained from limping about, no permanent callus took place, but instead of that an osteo-periostitis suppurata extending to both the bones of the leg, with mortification of a great portion of the surrounding soft tissues. No phenomena however, of purulent absorption were manifest. I could but decide for a disarticulation of the knee joint, or for an amputation of the lower portion of the thigh; and of the two I selected this latter operation, being aware of the dangers which are likely to follow the opening of the knee joint's serous membrane. The amputation was performed under chloroform, and with the kind assistance of several gentlemen of this town, who, for love of humanity, contrived to overcome their natural repugnance to blood. The Esmarch's bandage was applied, and the circular method of cutting the soft parts used. No hæmorrhage of any importance took place, inasmuch as the first round-cutting of the muscles happened to leave the muscular fascia neatly discovered, so that I was able to tie the femoral artery before the second turn of the knife had discontinued it; the femur was sawn just above the condyles. No other vessel necessitated ligature after the removal of the Esmarch's bandage. The flaps were united by twisted suture, and a drainage tube was passed through the inferior angle of the wound. The dressing was made antiseptic, with a one per thousand solution of perchloride of mercury, this being the best poison known against micro-organism, since the studies of Dr. Koch. No first intention was obtained, except in a small portion of the higher end, but no great deal of divarication of the edges took place, and that which occurred was afterwards compensated and reduced nearly to nothing by the contractile power of cicatrization. An attack of fever overtook the patient on the first days after the operation, but the temperature did not exceed 104° F.; some sore-back was noticed, but promptly cured by a soft ring put underneath. Now one month has elapsed since the amputation was performed, and the cicatrix is quite closed. The boy cheerfully leaves his bed to move about with a pair of crutches, hopeful it will not be long before he be able to get an artificial limb, through the kindness of his good master.

ASSOCIATION INTELLIGENCE.

SOUTH AUSTRALIAN BRANCH.

MONTHLY MEETING.

Held at the Adelaide Hospital, January 29, 1885.

The President (Dr. C. GOSSE) in the chair.

The President reported that a copy of the motion respecting the appointment of City Health Officer, carried at the previous meeting, had been sent to the Mayor of Adelaide and the President of the Central Board of Health respectively, and the following was the substance of the reply from the latter. "In case of a vacancy the Health Act permits the Town Council to appoint (subject to the approval of this Board) a legally qualified medical practitioner or a properly qualified analytical chemist to the office of Health officer (clause 27, Act of 1873). Whether there is in Adelaide a chemist 'properly qualified' to carry out the instructions of the Central Board of Health, is open to question. I do not know one, and I think I may venture to speak for the other members of the Board, that they will not be likely to consent to a bogus appointment. I have noticed that there is before the City Council a proposal to reduce the salary of officer of health to such a figure that it is doubtful if any qualified gentlemen could accept it. This Board has no voice in fixing the salary."

The members present thought that it was only right that a suitable salary should be attached to the duties, and that it would be a great mistake for medical men to perform them gratuitously. They were also of the opinion that the public would be more likely to be better served if the Health officer were a paid official, than if the work was done for nothing; as in the latter case there would not be the same control over his actions, and he would feel himself less accountable to the authorities.

Dr. Lendon drew the attention of the President to the recent List of Members of the British Medical Association, in which a very imperfect and out of date list respecting the S. A. Branch was published.

EXHIBIT.—Dr. C. Gosse showed an infant, aged one month, that had a congenital cystic tumour, involving the buttock, rather larger than the child's head. It had been punctured, and a considerable quantity of clear straw-colored fluid had escaped, after which about 30 drops of Morton's solution was injected. This had been repeated on three separate occasions without any appreciable effect upon the size of the tumour, nor had it affected the child's health at all.

BALLOT.—H. S. Lloyd, M. B., Edin., was elected a member of the British Medical Association and of its S. A. Branch.

THE TREATMENT OF TYPHOID FEVER.—Mr. Dunlop wrote apologising for being unable to be present to open the discussion upon the treatment of typhoid fever. At the President's request, Mr. Hayward kindly undertook to do this.

Mr. HAYWARD, in rising, greatly regretted the announcement that had just been made, that Mr. Dunlop was unable to initiate the discussion on Typhoid Fever, and for two reasons; in the first place, he had looked forward to hearing that gentleman's views on the etiology of the disease, a most vexed question, and on treatment, and he felt sure that had he honoured them, they would have been able to gain some most useful information, for few of them had had the opportunities he had had of studying the disease in all its branches. In the second place Mr. Dunlop's defection had thrown a very awkward duty upon him, for he felt

that he could not refuse the request of the President, viz., to open the debate, though knowing perfectly well how impossible it would be to discharge the duty satisfactorily on so short a notice.

Without preparation, he did not feel justified in entering upon the etiology of typhoid fever, therefore, in the few remarks he should make, he would confine himself to the treatment, a point upon which they could all have something to say.

To lay down a routine course of treatment for a disease, the aspects of which are simply protean in their variety, would be manifestly absurd; each case must be treated on its merits, but that does not prevent one from enunciating a general idea. Treatment might be considered under three heads:—by drugs, by abstraction of heat, and by diet. For some years past, he believed the expectant method had found most favour with medical men. Patients with an ordinary attack of typhoid had been found to do as well without as with medicine, and at present he thought there could be little doubt but that they knew of no drug that has a specific action against the disease, but he did not think they should rest contented with such a belief; that they were unacquainted with any specific remedy, was surely no reason that it did not exist, and when they remembered that it was only a comparatively short time ago that they looked upon acute rheumatism as a disease that would run its stated course, no matter what drugs they employed, and considered now how well they had it in hand with Salicylic compounds, he did not see why they should not be hopeful that a remedy might not be discovered that would be as potent against typhoid as Salicin is against acute rheumatism.

A medical man, for whose opinion he had a great respect, told him last year that he felt confident that he had nipped in the bud an impending attack in himself by three or four large doses of quinine, 30 grains he believed, and though he had never had a similar experience, perhaps, through not having met with a case in a sufficiently early stage, he thought the idea was quite feasible. In several cases he had checked cases of what seemed to him impending typhoid, by repeated doses of Salicylate of Soda; but it was difficult to come to any reliable decision in such cases, for perhaps they would never have turned out to be that disease. On the other hand, he had undoubtedly mitigated the headache and other initial symptoms in cases that had ultimately developed the disease, by the same drug.

After the first week or ten days, he had found drugs of little or no use for the disease *per se*, but he often found that small doses of morphia were useful, especially when the bowels were in an irritable condition. He also found it useful in allaying the feeling of hunger, prior to and during convalescence.

To enter into the medicinal treatment for the many complications that arise, would take more time than was at his disposal, and he would therefore not touch upon it.

Treatment by means of abstraction of heat had of late years come into prominence, chiefly through the writings of the German physician, Dr. Cayley. This School advocated the use of the cold bath in nearly every case when the temperature rose above 102 deg. While not depreciating the value of this mode of treatment, he certainly thought that equally good results might be obtained by less heroic measures. For himself, he only resorted to the bath when the temperature nearly reached 106 deg. In these cases, when practicable, he put the patient in a bath, the temperature of the water being 98 deg., and rapidly reduced it to 70 deg., which he found, and the patient did too, was quite cold enough. This had the effect of bringing down the

body temperature to about 101 deg., and the result was that the patient calmed down and dropped into a quiet sleep. He repeated the bath on the temperature rising to 105 deg. In these cases he believed no treatment was so effectual or so grateful to the patient, but two cases in which alarming symptoms of shock supervened, showed him that it was not devoid of danger. In the large majority of cases, however, he felt sure that the beneficial effects of abstraction of heat might be obtained by sponging the surface of the body with tepid water, which had generally the effect of reducing the temperature one or two degrees. In some cases where the tendency had been for the temperature to run up rather high, he had found benefit by a modified form of packing, viz., of the arms and legs at different times. This proceeding had the advantage of causing little or no shock to the system.

Perhaps the most important factor in the treatment of typhoid fever was the regulation of the diet. He supposed it was pretty nearly universally admitted, that in this disease milk may be looked upon as the typical food, and patients fed on this alone usually did well. But while granting this, he must point out that in his opinion there were many cases that were better treated without; also, that under certain conditions, milk played the part of an irritant to the small intestines, and this was easily understood when they considered that the mucous membrane of the bowel was in a highly irritable condition, a condition not likely to be improved by the passage over it of large lumps of curd. In cases where there was diarrhoea, with undigested curd in the motions, he either stopped the milk or greatly reduced it in quantity, substituting either weak broths in fair quantity, or small quantities of concentrated meat extract, and generally with beneficial results. He never hesitated to allow any patient to drink as much cold water as they liked, within reason.

A few words with regard to the administration of alcohol. When he commenced practice, he held that alcohol was almost a *sine qua non*, but experience had led him to the conclusion that the large majority of cases did best without it. He held that it was useful to tide over emergencies, but to administer it as a matter of course, he considered to be unscientific and apt to do a considerable amount of harm.

He apologised for the imperfect manner in which he considered he had performed the duty entrusted to him, but must plead in extenuation the circumstances of the case.

Dr. ASTLES thought that as regards treatment, no absolute rule could be laid down, and that often drugs were unnecessary, and that careful nursing and attention to diet was all that was required. In cases where the diarrhoea was excessive, he had found nothing more satisfactory than the employment of solid opium. He considered that alcohol was of great service in certain cases, and that it frequently prevented patients from passing into that dangerous condition of exhaustion characterised by muttering delirium. Alcohol, as a remedial agent, required, however, great delicacy of handling, and there were numerous cases that never needed it. At one time he had had great expectations of the benefit arising from the use of antiseptic remedies, but after an extended trial of them he had lost faith in their efficacy to abort the disease. He did not believe that large doses of quinine were beneficial, but frequently prescribed it in small doses. He had noticed that profuse sweating was a very grave symptom, often defying all treatment.

Dr. LONDON said that although he had had the opportunity of attending the clinical practice of Sir William Jenner and other distinguished physicians who adopted the "expectant" method of treatment, he was

inclined to share the views of those who advocated the various methods of "anti-pyretic" treatment, and principally because he had witnessed such excellent results in the wards under the care of Dr. Cayley, the author of those able "Croonian" lectures on Typhoid Fever. The rationale of the method as he understood it, was this, that in fever we have to contend with various factors, which are all adverse to the patient, and that of these factors, the high temperature was the one most under our control, since it was possible to prevent the temperature of the body rising above a moderate height, throughout the whole course of the disease, and hence that we might obviate the injurious effects of the prolonged high temperature. The injurious effects were seen in the granular degeneration of the cardiac and voluntary muscles of the secreting cells of the various viscera, and the cells of the central nervous system, and it was stated by Liebermeister that 41 per cent. of the deaths were due to these degenerative changes. The high temperature could best be kept down by cold baths, and statistics showed that, whereas by the older methods of treatment the mortality ranged from 16 to 25 per cent., where the anti-pyretic treatment was partially carried out, the mortality was reduced to a maximum of about 11 per cent., indeed where he had been able to commence bathing before the sixth day Dr. Cayley had not lost a case; and during the Franco-Prussian war a German physician treated 93 cases without a death. He believed that the death rate at the Adelaide Hospital during the last epidemic was about 8 per cent. This raised the question whether typhoid fever was modified by climate, and he thought that the cases he had seen out here were milder on the average than those he had seen at home, but he included many cases that would be designated by the older practitioners "Colonial Fever." The treatment by baths to be successful should be commenced early, and the temperature not allowed to exceed 101 deg. or 102 deg. F., and it could be supplemented by the use of drugs, such as quinine, salicylate, &c., quinine being less depressing in his opinion. The contra-indications were few beyond the accidents of perforation, peritonitis, and hæmorrhage. It had been said that fever patients cannot "catch cold," and this he believed to be true, congestion of the lungs for instance occurring much more frequently where baths had not been given, and being due to the failure of the heart. It was generally urged that bathing was impracticable in private houses, and although he acknowledged the difficulty with adults, he did not think it insuperable, and with children it was easily carried out—indeed he had at the time a case under his care of a child who was bathed, with the result that it had always a moist tongue, slept well, and was free from delirium. Special symptoms required to be treated as they arose, and some alcohol was generally beneficial he thought, if the cases were at all prolonged. Of course the true treatment for Enteric Fever must be prophylactic, and when it was considered that it was less than 40 years ago that it was differentiated from Typhus Fever, there was every reason to hope that before long sanitary science would render the disease no longer endemic, and that some specific might be discovered which would cope with it, when it appeared in an epidemic or sporadic form. At present the tendency of medical research would seem to point to the possibility of the discovery of some method of cultivation and dilution of the virus, so as to enable it to be inoculated and thus render us insusceptible.

Mr. CLELAND said he could not profess to the possession of much clinical experience in typhoid fever, as the greater part of his professional life both in England and in this colony had been passed in connec-

tion with Lunatic Asylums. It seemed to him, however, that the treatment by cold bathing was not physiologically correct, and that its effect would not be to lower the temperature to such an extent as was generally supposed. This would apply if by cold bathing was implied water at a temperature many degrees below the normal heat of the body, say 60 deg. or 70 deg., but not if tepid water was used at a temperature of 97 deg. or 98 deg. A consideration of the physiological process by means of which the temperature of the body was maintained at a uniform rate would explain why this should be. The application of cold to the skin would drive the blood to the deeper portions of the body, and instead of aiding in the radiation of heat from the body, would interfere greatly with it, and most likely cause a higher temperature in the deeper important viscera. Another objection which he thought lessened to a fatal degree the benefit of placing a typhoid fever case in a bath, was the amount of movement that would be necessary. If there was one thing more generally accepted than another, it was the necessity of keeping the patient as quiet as possible. It might not matter so much, perhaps, during the very early stage of the disease, but he felt convinced that it would be a most hazardous proceeding during any of the later stages. He thought that all the good effects of bathing might be obtained more satisfactorily by the judicious use of the wet-sheet packing. As regards the efficacy of drugs he thought the indications evidently pointed to the use of some germicide, for there could be no doubt but that shortly some bacillus or other organism would be found having a causal connection with the fever. Quinine, salicylic acid, and strychnine belonged to this class, but in a very inferior degree as compared with boracic acid, carbolic acid, and corrosive sublimate. If the three latter could in some way be used in an unirritating form, such as a soluble albuminate of the last named, he thought that some satisfactory results might arise. The most effectual time for the administration of a germicide would naturally be during the very earliest stages of the disease. In connection with this, it might be worth considering the advantage of using this class of drug as a prophylaxis during any epidemic, or for those in attendance on specially virulent cases.

Dr. MACKINTOSH did not employ baths, as he found he could get all the benefit by sponging with tepid or cold water, and yet not fatigue his patient. He thought that it was of the utmost consequence to conserve, as much as possible, the strength of the patient. He used stimulants formerly, but had given them rarely of late, as he found that they often disagreed with his cases. He trusted more to supporting their strength by means of milk and mucilaginous drinks, and he found that greater success attended his practice since. To check excessive diarrhoea, he used small doses of Dover's powder, with good results.

Mr. JAY thought no routine rule could be laid down for treatment, nor any particular drug advocated. He quite agreed that every means should be taken to keep down the temperature, and he had always found that sponging with tepid water, with occasionally a little alcohol in it, produced satisfactory results, reducing temperature, calming the patient, and relieving delirium; only using the treatment by baths in very severe cases. He usually gave quinine as a tonic and anti-pyretic, and treated symptoms as they arose. He thought that diarrhoea should not be checked too much, six stools per diem not being too frequent. Opium and starch enemata he found useful when required. He thought that often the lung symptoms wanted as much attention as the intestinal, and were very serious. He

found alcohol very useful in such cases, especially where there was nocturnal delirium. Diet was very important, as was also watching for any changes in the symptoms. He had known cases lost for want of skilled watching.

Mr. MITCHELL remarked that none of the previous speakers had referred to bed-sores as a complication in typhoid fever. He had been so much troubled by them that he was constantly on the look-out for them. In fifty cases, ten of the patients had shown a tendency to them. He found vaseline a good preventive. The treatment of the fever was, in his opinion, purely expectant—sponging and attention to diet being his principal stand-bys. He thought diarrhoea was often caused by errors in diet, and that if the food were changed, the diarrhoea would stop without the employment of any medicine. He said there were undoubted cases of typhoid fever aborting on the sixth day and then constantly relapsing for the next three or four weeks, preventing the patients getting about their work. He had also noticed the absence of spots in many cases, about 12 in 50.

Mr. A. A. HAMILTON thought that the indiscriminate use of medicine was injurious. He had often found that where milk alone was not borne well by a patient, mixing it with a well beaten-up raw egg made it much more digestible. He could bear personal testimony to the very comforting effect of solid opium, as he found it relieve the very troublesome flatulence which was so often a distressing symptom, and he thought that it must exert a beneficial influence on the healing of the ulcers. He found it impossible to diagnose the fever with any certainty in the earliest stage, but when he had any suspicions, he was in the habit of giving a good purge of calomel. With reference to antiseptic treatment, he thought carbolic acid might be of use if given with sufficient freedom. He had been surprised at the amount of carbolic acid that could be taken without apparently any injurious effect. Lately, he had had occasion to give a child 6 months old some carbolic acid in erysipelas, after perchloride of iron had failed to check the disease; and he gave a grain of the solid acid every hour for thirty-six hours, with beneficial effect. He thought that the external use of cold water was contra indicated where hæmorrhage from the bowels was feared. He had not noticed bed-sores as a common complication.

Dr. C. GOSSE did not approve of the indiscriminate use of the cold bath. It might be suitable for children, but he could not believe that it was for adults. He however, strongly approved of the sponging as being most refreshing and useful in carrying off some of the excretions of the body. He was surprised that no one had referred to the employment of ice internally, as he was sure that it was very pleasant to the patient, and produced no injurious effect on the bowel. He was in the habit, whenever pain was complained of in the abdomen, of placing a piece of spongiopilin over the whole, and keeping it moist. He did not think hæmorrhage was necessarily a bad sign. He thought that the cases of typhoid fever in the colony were not so mild as had been supposed, as a temperature of 105 deg. and delirium were constantly recurring symptoms. He found lead and opium a useful combination when hæmorrhage of the bowels took place. He was in the habit of giving quinine in small doses, and he often gave it when he was merely suspicious of the patient being in the incubation stage of the disease. He did not believe in the large doses advocated by some. He had not noticed bed-sores as a rule; on the contrary, quite the exception. Spots were not a constant symptom, and in some years were more plentiful than others.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, MARCH 15, 1885.

EDITORIALS.

THE PROFESSION IN NEW ZEALAND.

WE regret to find from various newspaper and other reports, that the "esprit de corps" of the profession in New Zealand is at so low an ebb as to create unnecessary scandal, and that members of the profession have, without proper consideration, made public outcry about matters that, in the interests of the profession and the public, would have been much better referred to a meeting of members of the profession, and the decision arrived at by it accepted and acted on by the interested persons.

In almost every case in which the professional conduct of a medical man is called into question, there are incidents which to the outside public appear of the most trifling character, but which, to members of the profession, are of the utmost importance. The social standing and mental ease of the practitioner may depend on the care with which they are treated, and the life and well-being of patients may depend on fitting observance of established rules of professional conduct. A member of the profession may so put himself beyond "the pale" by his neglect of what is socially and professionally due to his brethren, as to render it impossible for any man of good standing to have any intercourse with him, and consequently, patients who are so unwise as to consult a man under deserved professional ostracism, may find themselves with their chances of recovery rendered more slender, perhaps, by the impossibility of such a medical attendant being able to obtain the necessary assistance from other medical men in an unavoidable operation, which thus may never be done at all, or the patient's transfer to some other practitioner who is not a professional pariah, so delayed as to be past the time when an operation could be successful.

The more prominent recent cases are, first, one in the Christchurch Hospital, in which Dr. Stewart operated for the radical cure of hernia, the patient unhappily dying. The patient went into the hospital specially for the performance of the operation, and every precaution seems to have been taken for his well-being. The sole cause of complaint appears to have been that a consultation was not held by the staff on the case, before the operation was done, and Dr. Nedwill appears to have been the sole professional malcontent, saying that the operation ought not to have been performed, &c. His sole legitimate ground for dissent seeming to have been the fact that a consultation was not called, and as, consequently, he could have had no accurate knowledge of the case, we are at a loss to understand on what grounds he presumes to make such a dogmatic assertion in the face of the opinions of the operating surgeon, Dr. Stewart, and of the resident surgeon, a man of experience, and of the desire of the patient (for some attempt to be made for his cure), a most important factor in such a case. For it is generally a matter for the choice of the patient, whether he will continue to depend on a truss for the prevention of the protrusion of his hernia, with all its possibilities of strangulation, or whether he will take the risk of an operation, which if successful, gives him comfort and safety for life. We may say that Dr. Stewart has the sympathy and professional support of the leading practitioners in Christchurch, and that he has since been elected chairman of the hospital staff.

The rules of the hospital seem to be very lax in regard to consultations before operations, and to have fallen in a great measure into disuse, and this we think a matter for regret, as a consultation divides responsibility and avoids unnecessary and unjustifiable scandal, as in this case, though we fear the strictest adherence to the most rigid rule for the holding of a consultation will not insure the recovery of the patient operated on.

Dr. Nedwill has resigned his position on the hospital staff, and in this we can but think he has wisely studied his personal ease, the well-being of the institution, and the comfort of the medical staff, for "a house divided against itself," &c., &c.

A long and not very lucid letter on the case appeared in the *Lyttelton Times*, written by Dr. Bakewell, who, if he is accepted as a professional authority, must have ceased to advertise his greatness in the manner we so strongly condemned in our October number, 1883, though his recent letter has a somewhat similar flavour.

The second case is one at the Wellington Hospital, in which Dr. Fell sent a patient to the institution, who turned out to be suffering from

some highly infectious disease, which was, presumably, puerperal peritonitis, though it was not a very evident case, and it is easy to be wise after experience gained. The particulars to hand show that Dr. Fell was called to an unfortunate woman without friends, means, or the barest essentials for treatment, without accommodation and without nursing. What was he to do? Let the patient die, or send her to an institution for the treatment of disease? We think the latter, but also think that the case, which was somewhat anomalous, should have been isolated from the rest of the patients. Here we think the responsibility rests with the resident surgeon, Dr. Chilton, who should have sufficiently examined the case to have shown the necessity of calling a consultation of the medical staff as to the mode of the woman's reception and treatment in the matter of isolation. The blame, if blame there is, in this case, seems to rest equally upon Drs. Fell and Chilton.

LEADING ARTICLE.

ON COCAINE, THE ALKALOID OF ERYTHROXYLON COCA.

BY DAVID COLLINGWOOD, M.D., B.S., LOND.,
F.R.C.S., ENG., SUMMERHILL, NEAR SYDNEY,
LATE SENIOR DEMONSTRATOR OF ANATOMY
AND PRACTICAL SURGERY AT UNIVERSITY
COLLEGE, LONDON.

ANYONE who has followed the accounts which have appeared from time to time in the medical papers of the investigations into the action and uses of cocaine, must have been struck with the rapidity with which it has come into favour in England, and with the great extent of its applicability. A short summary of what has been published up to the present time about the so-called "new anæsthetic," may, however, be useful, and must be interesting to many who have not time or opportunity to follow the disjointed accounts which have hitherto appeared.

The alkaloid is prepared from the leaves of the *Erythroxylon Coca*, a shrub which grows on the slopes of the Cordilleras of Bolivia, Peru, and Columbia. The leaves of this shrub, which grows to about 6 feet in height, and resembles English blackthorn in appearance, are closely placed, alternate, about 2 inches long, oval oblong, entire at the margin, blunt and emarginate, with a small apiculus in a notch at the apex, thin but opaque, smooth, with a prominent mid-rib, and on each side a curved line running from base to apex. The upper surface of the leaf is dark green, the

lower is pale and has well marked venation. Their odour when dried is like tea, and the taste is bitter and aromatic, and more active in the fresh than the dried specimen. The plant flowers with a small, white, short stalked flower in clusters. It has been acclimatised in Ceylon, and could probably be easily raised in this climate at a level of about 2000 feet above the sea.

The use of the leaves was known to the aboriginal Indians prior to the conquest of South America by the Spaniards. Among them, as among miners and travellers in South America ever since that time, the leaves were usually mixed up with the ashes of calcined shells and made into boluses, which were then dried and carried on journeys to be sucked at intervals. In our own times the leaves have been used as stimulants by persons making ascents of high mountains, amongst others by the late Sir Robert Christison, who published his observations on the sustaining power of the drug. The pedestrian Weston was noticed, when first in England about 8 years ago, to be constantly chewing something while on his long-distance walking feats, and he confessed, after some hesitation, that it was the leaves of coca, which he used to alleviate thirst and hunger. In addition to this effect, the drug, when taken by the mouth, steadies the nerves, gives endurance, and the power of resisting the effects of rarified atmospheres, removes fatigue and drowsiness, and produces exhilaration of spirits, without any disagreeable after effects, either mental or physical. The temperature of the body is slightly raised, the pulse and respiration quickened, while nutrition is said to be improved under its action. It is right to state that, according to Dr. Weddell, ill effects are sometimes produced in persons who become addicted to its use, especially a peculiar aberration of the mental faculties indicated by hallucinations.

The preparations of Coca are—

Vinum.

Ext. Liquidum, a French preparation.

Elixir.

“Valoid” of Coca.

Ext. Erythroxyli Fluidum, United States Pharm.

Suppositories.

Compound Tincture, with hops.

Alkaloid, Cocaina or Cocaine.

The alkaloid is chemically different to caffeine, the alkaloid of coffee, and is less soluble in water. It is a strong base, and forms several salts, of which the most useful is the hydrochlorate. This salt appears in commerce as a white amorphous powder, but in reality consists of small slender needles; it is soluble in water, 1-4, and freely soluble in spirit, oil of cloves, etc. The citrate

has been recommended for use in dental work, and the salicylate for ophthalmic work because it keeps well in solution.

The alkaloid was first isolated by Niemann in 1859, and in 1862 a second principle, hygrin, was discovered by Lessen; the latter probably gives the peculiar odour in cocaine, being present as an impurity in small quantities in most specimens of the latter. Niemann evidently knew its action to some extent, and Prof. Schrott first showed its effects in producing insensibility when applied to the mucous membrane of the tongue.

In 1874 Dr. Hughes Bennett published an exhaustive research into the action of the drug and its alkaloid, and showed that the anæsthetic effect was produced by an action on the sensory nerve endings, and not on the central nervous system. In the same year Dr. Ott showed that, applied topically, it acted as a mydriatic, while later on, in 1880, Dr. Von Aurep published a research into its action, in which he hinted that it would prove useful as a local anæsthetic. But the attention of the profession was not really aroused until after the publication of Dr. Carl Koller's paper, read before the Ophthalmic Congress at Heidelberg, on Sept. 15, 1884. That paper was translated and appeared in the *Lancet*, Dec. 6, 1884, and from that time onwards the action of cocaine has been investigated and reported upon by many observers.

Effects and action of Cocaine.—When applied in solution to mucous membranes, a constriction of the small vessels of tissues, whether healthy or inflamed, results, and the same is true after its application to cuts or abraded surfaces of skin, so that it stops or checks bleeding.

Next it produces loss of sensation to touch and pain, but only diminution of sensation to thermal impressions. This action is evidently produced by a direct paralysis of the sensory nerve endings, the motor being unaffected, and it contrasts therefore with curare, which paralyzes the motor nerve endings. These effects are produced in from 3 to 8 minutes by the application of solutions about the strength of 4 or 5 per cent.

In mucous membranes containing *special nerves* endings, as the tongue, these are acted upon by cocaine also, and all the forms of taste are obliterated, as well as the ordinary sensations.

When applied to the skin in solution in oil of cloves, it produces similar effects in a rather longer time and to a less degree, because of the lesser readiness of the skin to absorb.

When applied to the *conjunctiva* the effects are as follows:—at first a sensation of burning, with lachrymation, next a sensation of dryness followed at once by diminution and loss of conjunctival sensibility and reflexes. The palpebral fissure is

enlarged, the pupil is dilated, there is some loss of accommodation, but the pupil reacts fairly to light and to convergence. Ophthalmoscopic examination shows pallor of the retinal vessels, and palpation shows that intra-ocular tension is lessened.

The dilatation of the pupil is said by Koller to reach its maximum in 1 hour, and to diminish and disappear after a few hours, but in Dr. Renton's case it is said to have lasted a week. Most observers are agreed that it lasts only a short time. By some it is said to be preceded by a contraction, and the writer can confirm this by his own observations.

The question of loss of accommodation has been disputed. Dr. Koller calls it a paræsis, but some observers, from experiments on themselves, have described it as a distinct loss of accommodative power (Bickerton, Brit. Med. Jour., Jan. 10, 1885). It is certain, however, that the dizziness usually experienced in atropine mydriasis is not present in the action of cocaine. Vision becomes somewhat indistinct, partly on account of the dilatation of the pupil, and partly also on account of the changed curvature of the cornea, the result of the lessened intra-ocular tension.

The enlargement of the palpebral opening gives a peculiar staring and fixed expression, and is obviously a very great convenience and advantage. Its causation is disputed, Dr. Koller considering it to be due to the anæsthesia and absence of reflexes, while Mr. Walter Jessop (Ophthalmolog. Soc., Jan. 8, 1885), maintained that it is due to retraction of both lids by irritation of the unstriated muscular fibre contained in them, probably through their nerve supply from the sympathetic.

The dilatation of the pupil is interesting when compared with that caused by atropine, the latter being due to paralysis of the sphincter, while the cocaine mydriasis is probably due to stimulation of the radiating fibres of the iris.

The effects of cocaine when injected hypodermically were investigated by Messrs. Arkle and Brock, of University College, London, and published in two very interesting letters to the British Med. Journal. They showed that smarting, followed by numbness, were the first effects, with redness round the point of injection; anæsthesia followed in two or three minutes, the sensations of pain and temperature being abolished, while that of touch was diminished. The area of this anæsthesia was about 1 square inch for injection of $\frac{1}{2}$ gr. of the hydrochlorate, but was not regular in shape. The effects on the general system of injections in larger quantity gave contradictory results, sometimes quickened pulse, with exhilaration of spirits, at other times depression, with a sense of weight and sighing respira-

tion. On the whole, it may be concluded that small doses are sedative, large doses stimulating; and it has been said to produce "spontaneous convulsions" when given in large quantity.

The uses of cocaine may be gathered from what has been noted as to its effects. Its therapeutical value lies in (1) its anæsthetic, and (2) its narcotic effects. As an anæsthetic it is of the greatest possible value (a) in examination, and (b) in operation, whether the examination or operation be on the eye, ear, mouth, tongue, pharynx, larynx, nose, trachea, urethra, bladder, vagina, or rectum. In all these regions of the body it has been used with almost uniform success. For example, at St. Peter's Hospital, London, Bigelow's operation of lithotripsy was performed in December last in a quarter of an hour, painlessly, after the injection of $\frac{1}{2}$ oz. of a 4 per cent. solution of hydrochlorate of cocaine.

The operation for repair of recto-vaginal fistula was performed in the same manner, the patient feeling the "burning of the cautery but no pain." The cervix uteri has been divided, circumcision and even internal urethrotomy have been performed without suffering to the patient, and without the inconvenience and danger of chloroform or ether.

In ophthalmic work it has been used for

Extraction of cataract.	Discission.
Iridectomy.	Tenotomy.
Conical cornea.	Removal of pterygium.
Iridectomy	Scraping ulcers.
Stitching wounds of sclerotic, excision.	
Removal of foreign body, etc., etc.	

In nasal and aural surgery it has been useful in the removal of polypi; in dental surgery for the soothing of an inflamed pulp, or externally for periodontitis; and as an anæsthetic, with fair success, during the excavation of a diseased pulp cavity. For this latter work it is best applied as a glyceride.

Cocaine has even been used as an anæsthetic in the performance of the operation of vaccination.

As a narcotic in ophthalmic surgery, it is most useful in the treatment of keratitis* and iritis; for photophobia and blepharospasm; and by its astringent and pupil dilator effect, for conjunctivitis and the rupture of iritic adhesions; also in treatment of glaucoma by lessening intra-ocular tension.

It is also very useful in the treatment of acute tonsillitis and of laryngeal phthisis or any other condition causing difficulty of swallowing. Among other things, Dr. Morell McKenzie recommends its trial in cases of hay asthma.

* In the treatment of keratitis, Mr. Lloyd Owen, of Birmingham, recommends an 8% solution of the hydrochlorate of cocaine, with an equal part of liq. atropine sulph. (B. P.) as having been more successful in his hands than the atropia alone.

As a narcotic, too, it has proved successful in the treatment of vesical and rectal tenesmus and of vaginismus, for the relief of neuralgia, for painful ulcers, for the pain accompanying herpes zoster, acute eczema, urticaria, acne rosacea and lichen planus; for its application in these skin diseases and ulcers Dr. Colcott Fox recommends a preparation made with the so-called cocoa-butter.

From its general effects coca would probably be useful also in the treatment of insomnia, impotence (its action is aphrodisiac), spermatorrhœa, and nervous debility.

Dose.—When used topically for ophthalmic purposes and the like, a solution of the salicylate or hydrochlorate, about 4 % is the best. For external application to the skin, as for dental purposes, a greater strength, 10–20%, is needed. Internally, about $\frac{1}{2}$ –1 gr. of the hydrochlorate may be administered, or 3ss.–3j. of the fluid extract of the leaves.

Toxic effects have been described, and Dr. H. Knott, of New York, has written a good deal by way of caution in the use of the drug; he describes pallor, faintness, thirst, cold perspiration, stertorous breathing, &c.; but large doses of 5 grs. of the alkaloid frequently repeated have been taken without ill effects by some of the later observers.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

- Dowd, Charles, M.R.C.S., Eng., 1860.
 Worrall, Ralph, M.D., Q.U., Irel., 1878; Ch.M., Q.U., Irel., 1878.
 Lowe, Septimus, M.B., Darham, 1884; L.S.A., Lond., 1879; L.R.C.S., Edin., 1882.
 Boake, William, L.A.H., Dub., 1884; L.R.C.S., Irel., 1883.
 Tresidder, Harry Inola, L.R.C.P., Lond., 1883; M.R.C.S., Eng., 1883.
 Baldwin, George Pearce, L.R.C.P. & L.R.C.S., Edin., 1881.
 Chisholm, William, M.D., Lond., 1883; M.R.C.S., Eng., 1880.
 Lang, William Henry, M.B. & C.M., Edin., 1882.
 Gillespie, William, L.R.C.S., Edin., 1878; L.R.C.P., Edin., 1882; F.R.C.S., Edin., 1883.
 Branson, George Attenborough, M.R.C.S., Eng., 1881; L.R.C.P., Edin., 1881.
 Gray, John Roubel, M.B. & C.M., Aberd., 1873; M.D., Aberd., 1876.

QUEENSLAND.

- Redmond, Leonard, L.S.A., Lond., 1880.

VICTORIA.

- Grant, David, M.B. & Ch.M., Edin., 1876.
 Evans, Cadwallader Edwards, M.R.C.S., Eng., 1884; L.R.C.P., Lond., 1884.
 Fleming, Harloe Henry, M.B., Dubl., 1883; Ch.B., Dubl., 1884.
 Lillies, Herbert, M.R.C.S., Eng., 1879; L.R.C.P., Edin., 1882.
 Docking, Thomas, M.D., St. And., 1868; L.R.C.P., Edin., 1867; L.M.D., Edin., 1867; L.S.A., Lond., 1868; M.R.C.S., Eng., 1866.

Additional Qualifications registered:—

- Boyd, James Dunlop, M.D., Glasg., 1884.
 Ryan, James Patrick, M.K.Q.C.P., Irel., 1884.
 Duncan, Robert Byron, F.F.P.S., Glasg., 1884.

THE MONTH.

NEW SOUTH WALES.

THE Ambulance Corps which accompanied the N. S. W. Contingent of troops for the Soudan, consists of Surgeon-Major Dr. W. D. C. Williams (of Darlinghurst, Sydney) in command; Surgeon Dr. Doyle Glanville (late Surgeon of P. & O. R. M. S. "Rome"), and Surgeon Dr. Geo. Proudfoot (late of Byerock). Also two non-commissioned officers and two dispensers, together with 24 trained bearers, many of whom are men of long service in army hospital corps, five drivers, and one trumpeter. There are five ambulance waggons, fully fitted up on latest service principles, each waggon to carry seven wounded—two on front seat, two inside on stretchers, which have been so arranged that when in position but very little motion will be felt, and three on the back seat. There are also two pharmacy and surgical waggons, fitted with instruments, drugs, medical comforts and medical panniers, in such a way that each article is placed in boxes and drawers, which are lettered and numbered, so that the articles can be at once procured. Two waggons will be provided for carrying tents, both hospital and operating; bedding, clothes, and reserve stores; two field waggons, fitted up to carry general hospital stores; one water-cart.

A SPECIAL meeting of the Senate of the Sydney University was held in the rooms of the Royal Society, on February 18. An application from the lecturer in *Materia Medica* (at present absent on leave in Europe) for an extension of his leave, was referred to the Dean of the Faculty of Medicine for report. A letter from Dr. Milford, lecturer in surgery, offering a gold medal to the best student of his class, was fully considered. It was the opinion of members that a gold medal, which is the highest distinction the University offers to candidates for degrees, should not be awarded upon the results of a mere class examination, but that the lecturer should be permitted to award a prize of books or instruments in his own name, if he thought fit. In connection with the appointments to the Clinical Lectureships in the Medical School, the following resolutions were adopted, on the motion of Professor Stuart:—"1. That the endowment of the Clinical Lectureships be at the rate of £50 per annum, instead of £100 per annum as provided in the scheme; and that there be two such lecturers in Medicine and two in Surgery. 2. That, subject to the conditions contained in the resolutions of the Senate touching such appointments, Drs. Shewen and Hurst be appointed lecturers on Clinical Medicine, and that Drs. Fortescue and Goode be appointed lecturers on Clinical Surgery. 3. That when these gentlemen are informed of their appointment they shall receive a copy of these resolutions, and be informed that their lectures shall be delivered in accordance with the curriculum and time-table of the Faculty of Medicine, and that they shall lecture alternate terms."

THE Directors of the Prince Alfred Hospital, having in a communication to the Royal College of Surgeons, England, stated the number of beds and the opportunities for clinical study in the hospital, and requested the recognition of the hospital for the purpose of qualifying for the diplomas of the college, have received the following reply:—"Royal College of Surgeons, Lincoln's Inn Fields, January 5, 1885. Sir, I have submitted to the Council your letter of September 27 last, on behalf of the Board of Directors of the Prince Alfred Hospital, Sydney, N. S. W., requesting the recognition of the hospital by the college, and am desired

to acquaint you that the Council have resolved that the Prince Alfred Hospital, Sydney, be added to the list of colonial hospitals recognised by the college. I am, Sir, your obedient servant, EDWARD SUMMER, Secretary. To the Hon. Secretary Prince Alfred Hospital, Sydney."

THE Senate of the Sydney University, at their last monthly meeting, resolved, on the recommendation of the Dean of the Faculty of Medicine, that an extension of leave, without salary, be granted to Dr. Thos. Dixon, lecturer in materia medica, until the commencement of Lent term, 1886; and that Dr. Alex. MacCormick be appointed to deliver a course of 60 lectures upon materia medica during Michaelmas term, 1885, at a cost equal to the salary of the lecturer.

THE Directors of the Prince Alfred Hospital, Sydney, have arranged with the Senate of the University and the Medical Board of the Hospital a course of hospital clinical study in accord with the University curriculum, and 14 students have entered their names upon the Hospital books. The experience of the last three years shows that the cases admitted for treatment are of a type unusually well adapted to afford clinical instruction in the various branches of medicine and surgery, while the facilities available for teaching and study are already numerous, and will be complete when the operation and speciality building is finished. The Hospital now contains wards for diseases of women and children, for diseases of the eye, an operating theatre, four special wards for serious operations, and a clinical lecture room.

THE annual report of the Prince Alfred Hospital, Sydney, shows that the total number of admissions from October 1, 1883, to December 31, 1884, was 1830. The total number of those discharged cured has been 953. The total number of those discharged relieved has been 483. The total number of those discharged unrelieved has been 186. The total number of those who died was 244. The number of accidents admitted has been 211. The number of operations has exceeded 200, many of them having been of a severe and complicated character. The number of cases of typhoid fever admitted has been 220, and of these many were extremely ill, and some in a dying condition, when received. The average number of beds available for the reception of patients has been 140, exclusive of the four isolated cottages reserved for cases of infectious disease occurring within the hospital, and the one for patients suffering from temporary delirium. The number remaining in hospital on 31st December, 1883, was 138. The number of patients admitted as "necessitous," under the Colonial Secretary's order, has been 1064. The number admitted into the general wards without such an order has been 752, and of the latter 624 have contributed more or less towards their support. The total sum collected from patients amounted to £2781 12s. The average period of residence of patients who themselves paid £1 per week and over has been 25 days; the average period of residence of patients who paid sums of less than £1 per week, and of those admitted under the Colonial Secretary's order, has been 40 days. Twenty-one (21) patients have been received into the 'Ogilvie' and 'Fairfax' private wards. The out-patients' department is a highly popular branch of the institution, and it has been found necessary to establish stringent rules to confine it to the indigent class, for whose benefit alone it was established. The number of attendances has been 17,186, and of the accident and urgency cases attended as outdoor casualties has been 290.

DURING the past year 170 patients were admitted into the Sick Children's Hospital, Glebe, Sydney; 136

were discharged, 17 died, and on December 31, 1884, there were 37 remaining in the Hospital.

THE Government intend to erect a temporary iron hospital at Mitchell, Sunny Corner, near Rydal.

TYPHOID Fever is prevalent at Glen Innes.

DR. JAS. BRUCE, late Resident Medical Officer at the Sydney Hospital, has commenced practice at Newtown, a suburb adjoining Sydney.

DR. W. H. COUTIE, late Resident Medical Officer at the Sydney Hospital, has commenced practice at Petersham, a suburb of Sydney.

DR. HEDLEY, of Brushgrove, was severely kicked by a horse which he was driving in a buggy on February 16. The animal first smashed the splash board, and then kicked the doctor on the chest, necessitating his going to Rocky Mouth for medical attendance.

WE regret to hear that Dr. A. Johnstone, of Parkes, was thrown from his horse on March 3, and severely cut about the head and face. It is also believed that his spine is injured. Dr. M'Donnell, of Forbes, is in attendance.

DR. J. P. KEALY, of Hillston, has removed to Gulgong, a gold-mining township, 200 miles W. of Sydney.

DR. G. H. KNIGHT, late of Elizabeth Street, Sydney, has commenced practice at Leichhardt, a suburb of Sydney.

DR. C. W. PARDEY, late of Kiama, and formerly Resident Medical Officer at the Sydney Hospital, has commenced practice at Hillston, on the Lachlan River, in a pastoral district, 435 miles west of Sydney.

DR. VALLEE, has succeeded to the practice of Dr. C. F. Gray, at Inverell.

DR. W. B. VIOLETTE, late Resident Medical Superintendent of Little Bay Coast Hospital, near Sydney, has been appointed Coroner at Woodburn, including Coraki and Wardell (Richmond River District), and for the Colony generally.

NEW ZEALAND.

THE Board of Management of the Auckland Provincial Hospital, have adopted the report of the House Committee, recommending that Dr. Bond, the house surgeon, be requested to resign. They were of opinion that he had been guilty of harshness and arbitrary conduct towards a certain patient; however, they did not in the least reflect on his professional zeal or proficiency. It was also decided to send the full report to the Government.

DR. A. GINDERS, of Rotorua, has been appointed a Member of the Licensing Committee, for the special licensing district of Thermal Springs.

DR. F. W. INNES, a new arrival, has settled at Gisborne (Poverty Bay), in a fine agricultural and pastoral district, 250 miles south-east of Auckland.

DR. D. STALKER, of Burleigh Street, Kyber Pass road, Auckland, has removed to Kaitangata, in a coal-mining and farming district, 60 miles S.W. of Dunedin.

DR. WM. NELSON, of Cromwell (Prov. Otago), has accepted the appointment of Assistant Medical Officer at the Seacliffe Lunatic Asylum, Dunedin.

DR. F. MCB. STEWART, Honorary Medical Officer at the Christchurch Hospital, whose action in performing an operation on a patient in the hospital without consultation, formed the subject of an inquiry, has been elected by the hospital staff as their chairman.

QUEENSLAND.

A HOSPITAL is to be established at Boulia, Northern Queensland.

THERE is a great deal of sickness in Rockhampton at present. Typhoid fever is general, and the deaths from dysentery are more numerous than at any previous time.

DR. W. S. O. BYRNE, late of Maryborough, and formerly Resident Medical Superintendent of Prince Alfred Hospital, Sydney, has commenced practice at Beaconsfield Terrace, Brisbane.

DR. CHAS. DOWD, formerly Medical Officer of the Hodgkinson Gold Fields District Hospital, intends to settle at Gympie, a rising gold-mining township, 117 miles north-west of Brisbane.

DR. J. C. ELLISON has commenced practice at Stanley Villa, South Brisbane.

DR. E. K. OVEREND, a Melbourne graduate, has settled at Muttaborra, the centre of a large pastoral district, 850 miles N.W. of Brisbane.

MR. JOHN TUCK, M.R.C.S., Eng., et L.S.A., Lon., 1868, Medical Officer to the Tambo Hospital, and formerly of Seymour (Vic.), died suddenly at Tambo last month.

SOUTH AUSTRALIA.

At a meeting of the Adelaide Hospital Board, held on February 27, it was reported that 42 cases of typhoid fever had been admitted into that institution since the middle of December from various parts of the colony, including 11 admitted during last preceding week.

At the Burra Burra Hospital, 186 cases have been admitted during 1884, and of these 19 have died, 123 have been cured or had their complaints alleviated, 19 showed improvement, 2 were sent to lunatic asylum, 1 was sent to destitute asylum, 2 were decided cases of malingering, 1 was returned to Gladstone goal, 5 were improved, and 14 remained in the hospital on December 31, 1884.

DR. S. K. ELLISON, of Adelaide, has been appointed Honorary Secretary of the South Australian Medical Board, vice Dr. Wyatt, resigned.

A SORT of panic has set in at Hergott Springs in consequence of the outbreak of a fever, which is believed to be a low colonial or enteric fever. The number of persons affected is rapidly increasing, and many residents have already left or are going to leave the district. A hospital tent is on the ground under the charge of a medical man and a nursing staff. Dr. Paterson, the Colonial Surgeon, left Adelaide for Hergott on the 28th February, to inquire into the outbreak of the fever. Dr. Paterson, in his report to the Government, states that he found nothing to justify the scare. There were four patients in the Hergott Hospital, suffering from what is now called typhoid, but which was formerly known as colonial fever. Two of these patients were almost convalescent. Dr. Paterson had examined the water supply, and was of opinion that the alleged effects were due to drinking excessive quantities in hot weather—not to organic impurities.

TASMANIA.

DR. C. E. BARNARD, of Hobart, has been appointed Medical Officer for Gaols and Invalid Depôts, Health Officer for the Port of Hobart, Medical Attendant on Paupers, and Superintendent of Vaccinations, at a salary of £300 per annum. Dr. Barnard will not be

permitted to undertake private practice, but will be allowed the privilege of consultation practice.

DIPHTHERIA is prevalent at Latrobe.

VICTORIA.

At a meeting of the Council of the Melbourne University, held on March 2, the following clauses in the report of the committee appointed to consider the question of the extension of University teaching and buildings were passed:—"Further facilities for instruction in special medical and surgical subjects have been indicated as desirable. The committee are of opinion that instruction in diseases of the eye and ear, of the skin, and of other special organs, may be obtained by proper arrangements as part of hospital practice. Instruction in hygiene should be given in connection with therapeutics. Whether this arrangement can be effected without any increase in the number of medical lectures is a subject for further consideration. A certificate of knowledge of vaccination from a public vaccinator should be demanded, and could easily be arranged for. The most pressing need in connection with our Medical School is some control by the council or faculty over the appointment and work of medical officers of the hospitals. A special grant of £3,000 will be required for furnishing and fitting up the new Medical School." The report of the faculty of medicine concerning medical education was referred to the medical members of the council, the Vice-Chancellor, Drs. Cutts, Fetherston, and Motherwell, Professor M'Coy, and Mr. Ellery. A letter from the Melbourne Hospital, proposing that the University should collect the fees for the physicians and surgeons of the hospital, was referred to the same committee, as was also a letter from Dr. Springthorpe, suggesting a new course for degrees in medicine and surgery.

THE Melbourne Hospital Committee, at the suggestion of Dr. J. W. Springthorpe, one of the hon. physicians to this institution, have appointed a sub-committee to inquire into and report upon the question of providing a hospital for phthisical cases.

THE Central Board of Health distributed 1142 points of calf lymph in January.

THE last of the smallpox patients was released from quarantine on February 17.

MEASLES is very prevalent in Avoca. The health officer has reported over 30 cases.

TYPHOID Fever has broken out at Rushworth.

DR. H. H. FLEMING, a new arrival, has settled at Stawell, the centre of the Pleasant Creek gold fields, 175 miles N.W. of Melbourne.

DR. HEARN, Resident Medical Officer of the Hamilton Hospital, has been granted leave of absence for one year; Dr. Bennett, late of Stawell is to be his locum tenens.

DR. R. N. JACK, late of Mudgee (N.S.W.), has succeeded to Dr. Bennett's practice at Stawell; Dr. Bennett has removed to Hamilton.

DR. HERBERT LILLIES has commenced practice at "Dunmore," Sutherland Road, Armadale, a suburb of Melbourne.

DR. WM. MORRISON, late of the Belvidere Fever Hospital, Glasgow, has settled at Colac, the centre of an agricultural and pastoral district, 96 miles S.W. of Melbourne.

DR. RANKIN, of St. Kilda, is leaving for England. During his absence his practice will be conducted by

Dr. Edwards Evans, late assistant visiting physician to the London Hospital, and late house surgeon to Teignmouth Infirmary.

MR. WILLIAM RAE, L.R.C.S., Edin., 1857, Health Officer and Public Vaccinator for Bacchus Marsh and Melton, is dead.

DR. NOEL VANCE has succeeded to the practice of the late Dr. Wm. Rae at Bacchus Marsh.

MEDICAL APPOINTMENTS.

- Bulfield, Edgar George, L.R.C.P. & R.C.S., Edin., to be Public Vaccinator for the Helensville district, N.Z.
- Cahill, Thomas, M.D. & Ch.M., Roy. Univ., Irel., appointed Honorary Medical Officer to the Wellington Hospital, N.Z.
- Cortis, William Smithson, M.D., L.R.C.S., Edin., to be Public Vaccinator for the district of Port Macquarie, N.S.W.
- Dickinson, William Miller, M.B., L.R.C.S., Edin., to be Government Analyst for Hamilton, Vic.
- Gillespie, William, F.R.C.S., Edin., L.R.C.P., Edin., to be Health Officer for shire of Towong, Vic.
- Guthrie, Thomas Orr, M.D. & Ch.M., Glasg., to be Honorary Surgeon in the Lyttelton Naval Artillery Volunteers, N.Z.
- Horan, Edward, M.A., M.D. & Ch.M., Qu. Univ., Irel., appointed Surgeon to the Charters Towers District Hospital, also Medical Attendant to the Amalgamated Friendly Societies' Medical Union, Charters Towers, Qu.
- Hudson, James, M.B., Lond., M.R.C.S.E., to be Honorary Surgeon of the Nelson Naval Artillery Volunteers, N.Z.
- Johnston, Daniel, L.F.P.S., Glasg., L.R.C.P., Edin., to be Public Vaccinator for the Halcombe district, N.Z.
- Kealy, Joseph Patrick, L.R.C.S., Irel., L.K.Q.C.P., Irel., elected Medical Officer to Gulgong Hospital, N.S.W.
- Keyworth, John White, M.D., Lond., M.R.C.S.E., to be Surgeon Superintendent of the Napier Hospital, N.Z.
- Lacey, Charles William, M.R.C.S.E., L.R.C.P., Lond., to be Government Medical Officer and Public Vaccinator for the the district of Kiama, N.S.W.
- Lethbridge, Charles Frederick, M.R.C.S.E., to be Public Vaccinator for Darlingford, Jamieson, Gaffney's Creek, and Wood's Point, Vic.
- McCauleand, Edmond, L.F.P.S., Glasg., to be Public Vaccinator at Edenhope, Vic., vice Dr. F. D. Hayman, resigned.
- Maclean, David Purdie, L.R.C.S., Edin., appointed Staff Surgeon in the Victorian Naval Forces.
- McMahon, John, L.O.P.S., Low. Can., to be Health Officer for shire of Avoca, Vic.
- Nickoll, Edward Harvey Bird, L.R.C.P. & R.C.S., Edin., to be Government Analyst for shire of Romsey, Vic.
- Overend, Ernest Knight, M.B., Melb., to be Government Medical Officer at Muttaborra, Qu.
- Parkey, Charles William, M.B. & Ch.B., Melb., appointed Medical Officer to Hillston Hospital, N.S.W.
- Pearless, Walter Reif, M.R.C.S.E., to be Surgeon to the Waimea Rifle Volunteers, N.Z.
- Rohner, Charles William, M.D., to be Health Officer for shire of Yarrowonga, Vic.
- Ryan, Edward, M.B., Melb., to be Public Vaccinator at Nhill, Vic.
- Shaw, William, M.R.C.S.E., L.K.Q.C.P., Irel., to be Health Officer for shire of Barrabool, Vic.
- Stalker, Daniel, M.B. & Ch.M., Edin., to be Public Vaccinator for the Kaitangata district, N.Z.
- Symes, William Henry, M.D. & Ch.M., Edin., appointed Honorary Medical Officer to the Christchurch Hospital, N.Z.
- Violette, William Bradley, M.B. & Ch.M., Glasg., to be Government Medical Officer and Vaccinator for the district of the Lower Richmond River, N.S.W.

CORRESPONDENCE.

SPACE ALLOWED TO PATIENTS IN HOSPITALS.

(To the Editor of the A. M. G.)

SIR,—To settle a little dispute, in the absence of a text-book, I am requested to refer to you as to the amount of cubic feet of air (the space) to be allotted to each adult patient in a hospital in a temperate climate.

I remain, &c., ENQUIRER.

[Each patient ought to have not less than 100, if possible 120, feet of floor space, and a cubic air space of 1,500 feet, but for cases of infectious disease, or for severe surgical cases, as much as 2,000 feet should be allowed.—*Editor A. M. G.*]

A SIMPLE AND NOVEL METHOD OF TRANSFUSION.

(To the Editor of the A.M.G.)

SIR,—If the enclosed is original, as I believe it to be, no doubt you will be good enough to insert it in your paper for the benefit of your readers.

In reading the various accounts of the operation of transfusion that have appeared from time to time, it has occurred to me that none of the apparatus hitherto invented have been in conformity with the simplicity of the operation itself. They are generally more or less cumbersome or complicated, and yet do not ensure absolute immunity from danger, and for one reason or other do not find space in the obstetric bag.

The apparatus I would substitute for them is exceedingly simple. It consists of a glass funnel, an india-rubber tube, and a silver canula fitting it.

The first step is to obtain the blood and to defibrinate it; this being done, the recipient's vein is opened.

Now comes the most important step. The funnel is held up, with the end of the canula likewise held up only on a slightly lower level. The defibrinated blood is poured into the funnel until it is full, and the blood is spurting out of the canula when the finger is placed over its mouth.

The canula is now lowered, with the finger still over its mouth, until it is close to the recipient's vein, and the vein is held open to receive it. The finger is now removed, the blood immediately flows from the canula, which is directly inserted into the vein, so no air can enter from this end. The funnel must be watched, and when the fluid is just disappearing at the junction of the glass and the india-rubber, the canula must be immediately withdrawn, or of course air will follow the blood through the funnel and enter the vein.

Remarks.—(a.) The funnel may be filled as often as may be necessary, and the operation repeated, provided the funnel is not allowed to empty itself, but the safest course is to remove the canula from the recipient's vein and to repeat the whole process.

(b.) There are no cocks or taps, and no foreign matter can accumulate in the tube.

(c.) There is no danger of air entering if the funnel is made of glass, as directly the fluid is low in the funnel, the canula is removed from the vein.

(d.) The apparatus is very inexpensive, as the materials forming it and its simplicity indicate.

(e.) It is absolutely free from risk, and is very portable.

H. V. DREW, M.R.C.S.E.,
Resident Surgeon, Timaru Hospital, Canterbury,
New Zealand.

ADVERTISEMENT OF DIPLOMAS BY AN UN-REGISTERED PRACTITIONER.

(To the Editor of the A.M.G.)

SIR,—Referring to a letter signed M.D., Camden, published in your last issue, will you kindly allow me space for the following plain statement.

Your correspondent quotes an advertisement of mine in the *Campbelltown Herald*, and wishes to know if the degrees there mentioned, of L. et Lic. Mid. R.C.P., Edinburgh, are possessed by me, they not being registered by the Medical Board. In answer to this, I desire to inform him that I certainly do possess the degrees in question, or I, just as certainly, should not have stated such to be the case. As to my not having registered them, that, I think, is most decidedly my own private affair; but for his satisfaction, and also that of any other persons who so kindly take interest in so humble an individual as myself, I wish to give the following explanation.

I was informed by a medical friend in Sydney, that the Medical Board would refuse to register my American degree. Doubting this, I determined to present it for registration *on its own merits*. I have since found—for reasons which seemed then and still seem to me to be inadequate—that he was right. Such being the case, I shall (at my own earliest convenience) proceed to the registration of my Edinburgh qualifications, and then, perhaps, your correspondent and others of the same calibre, will rest satisfied that they have done their duty, and repose on the laurels so hardly earned.

S. E. HERBERT, M.D., L. et Lic. Mid. R.C.P., Ed., 1879.
Wellington, N. S. W., February 24th.

[We must say that we do not consider the above letter at all a satisfactory explanation of S. E. Herbert's advertisement. It is most improbable, and is quite contradicted by his own letter written from Picton, on October 9, 1884, and published in our October number. In this letter, to which we refer the writer and our other readers, after complaining that the Medical Board had refused to register his American diploma, says—"a man devotes all his early years to the study of a profession, and because—for family reasons of a pecuniary nature—he is not able to qualify in England, he is refused registration. Does the Medical Board recognise what it is doing by this refusal? It is keeping me from earning a living for myself and family, in the way in which of all others I am best qualified to earn it. I was offered a lucrative position in this colony, my diploma and testimonials were considered all that was necessary, and the only thing that was asked was that I should register. This I endeavoured to do, with the result before mentioned, and as a natural consequence I shall lose the appointment."]

We think the foregoing extract from his first letter is hardly compatible with the truthfulness of the account he gives in his second of the very interesting experiment he wished to carry out as to the degree of gullibility possessed by the Medical Board of New South Wales. In another portion of the same letter, he says that he was not three years engaged in the study of his profession as required by the New South Wales Board, but only a little over two years and a half; this alone puts the possibility of his possessing the L.M. and L.R.C.P., Ed., out of the question, as proof of four years study is required before a candidate is admitted to the examination necessary to obtain it. We condole with our correspondent on the badness of his memory.—ED. A.M.G.]

CORONERS AND THEIR DUTIES.

(To the Editor of the A.M.G.)

SIR,—May I beg the favour of your opinion on the following case:—

On January 12, at 6.30 a.m., a man was brought into township, in a spring-cart, for admission into the hospital. The driver of the cart called at my residence. I was out at the time, attending a midwifery case. At 8.30 a.m., when proceeding to my hotel, I saw the patient lying in the cart, suffering from shock. He had the following history:—At 1.30 a.m., whilst proceeding from a public house to his camp, he fell down an embankment a distance of some 15 feet, and was found lying at the bottom sometime afterwards. I at once admitted him into hospital, with a letter containing instructions to the warder, and then returned to my midwifery case, which terminated at 11.30. On returning to my house, the warder had sent a messenger to say that the patient was dead. I at once communicated with the police and coroner, and, after some deliberation, the latter said an investigation was unnecessary, and declined to give me instructions to perform a P.M. I understand the coroner here was appointed six months ago; he is a "new hand," and has not as yet held an inquest, or if so, ignores all medical evidence. In the above case, it is needless to say that I declined to give a certificate of death. Was I justified in doing so? I beg to enclose my card, but not for publication.

A GOVERNMENT MEDICAL OFFICER.

[We think the cause of death was so evident as not to need an inquiry as to its immediate factor. But in such cases an inquest should be held to ascertain the chain of events which led up to the violence producing the injuries, so as to determine whether they were the result of the victim's own action, or of the criminal violence or culpable negligence of another. In all cases where the evidence justifies suspicion that the fatal result arose from the unlawful action of another person, a post-mortem examination is essential in the interests of justice. We think in this case the hospital authorities are not blameless in leaving a man in so obviously dangerous a state in a cart for two hours, whilst waiting the opinion of the medical officer, at the time absent from home.—ED. A.M.G.]

THE PRINCE ALFRED HOSPITAL, SYDNEY, AND THE PRESS.

To the Editor of the A.M.G.

SIR,—Can you inform me why the representatives of the Press are not admitted to the Meetings of Directors of the Prince Alfred Hospital. I think the public would be better satisfied if the proceedings at these meetings were properly reported by the representatives of the Press, as they are at the Sydney Hospital, and which was done on account of the demand on the part of the public.

I understand that the press is supplied with the reports of the Meetings of the Prince Alfred Hospital, and that the report of the Annual Meeting of that Institution, so far as it referred to the large attendance of the public, was hardly founded upon facts.

Yours sincerely, SUBSCRIBER.

[We are making the necessary enquiries, and hope to be able to produce an article on the entire situation in a future number.—ED. A.M.G.]

A NEW GYNÆCOLOGICAL CHAIR.



The above engraving shows the Chair as a handsome Easy Chair. It is made of Walnut, finished in oil, with the engraved lines either black or finished in gold. It is upholstered with plain soft seat (no springs), tufted back and arms, and is covered with Maroon Leather.

WE believe we are doing a service to our readers in bringing this new Gynæcological Chair under their notice, as for ease in adjusting, convenience and comfort in operating, and solidity in structure, we consider it far superior to any other similar one.

By means of a crank at the side, the seat of the Chair is raised to any desired point, and the act of raising the seat causes the back to raise and fall over, so that when the seat is at its highest point the back is nearly horizontal and on a level with the same. The seat is raised as readily and easily with the patient in the Chair as when vacant.

Not only can we obtain the *Knee Chest* and the *Semi Prone* position perfectly, but we also possess a perfect Table for the treatment of cases in *Sims' Position*, either with a tilted pelvis or a level surface, as may be desired by the operator. At the same time it can be adjusted to the most desirable position for the treatment of Hemorrhoids, and with the use of the extra seat extension it can be made into a full length operating table, which will be level and of the desired width and height. It will also be seen by the illustration that attached is a slide under the seat, which, when drawn out, forms a convenient table on which to set the overflow basin, instruments, &c., and also forms a step or foot-rest for the feet when using the chair as a reclining chair.

These Chairs will shortly be obtainable in Sydney.



The above illustration shows the Chair in position for use with the Extra Seat Extension attached. Also shows the Platform or Slide drawn out.

REPORTED MORTALITY FOR THE MONTH OF JANUARY, 1885.

Cities and Districts.	†Population.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from							
				Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Child-bearing.
N. S. WALES.											
Sydney	103,379	247	130	...	1	6	1	9	31	22	1
Suburbs	120,832	359	228	...	4	4	3	13	52	21	2
NEW ZEALAND.											
Auckland	28,028	51	30	...	...	...	...	...	13	5	...
Christchurch.....	16,337	26	12	...	...	1	3	...	1	6	...
Dunedin	26,176	27	9	...	...	...	...	...	2	2	1
Wellington	22,717	31	10	...	...	...	2	...	...	3	2
QUEENSLAND.											
Brisbane	26,557	48	33	*	...	...	...	...	...	...	...
Suburbs	9,612	39	16	...	...	...	...	...	...	...	...
SOUTH AUSTRALIA.....	318,300	312	153	1	...	10	2	13	42	20	...
Adelaide	43,969	56	21	...	...	2	...	3	11	7	...
TASMANIA.											
Hobart	28,897	87	64	...	...	3	1	2	25	3	...
Launceston	18,131	57	41	...	...	...	2	...	7	5	...
Hospitals, Asylums, Gaols, &c. .	1,020	33	...	...	...	...	...	...	...	...	...
Country Districts.....	85,075	70	...	...	...	1	...	1	4	...	..
VICTORIA.											
Melbourne	65,791	90	285	3	...	5	9	12	66	64	6
Suburbs	238,618	502									

* The Official Monthly Report on the Vital Statistics of Brisbane and Suburbs does not show the number of deaths from the various diseases.
† The population of N. S. Wales, Victoria, and Queensland, is that of the census of 1881; New Zealand, South Australia, and Tasmania show the estimated population at the present date.

METEOROLOGICAL OBSERVATIONS FOR JANUARY, 1885.

STATIONS.	THERMOMETER.				Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.		Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E.....	...	98.4	70.8	48.6	29.852	Inches	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.....	143	77	64.4	50	...	1.900	9	65	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	172	97	80.3	60	29.948	0.61	9	67	N.E.
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.....	...	...	...	...	...	...	...	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.....	147	74	55.5	42	...	2.848	21	76	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.....	...	85	63.8	41.7	29.852	2.40	14	63	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E. ....	...	82	65.1	40	29.895	1.61	7	63	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	...	98.4	64.2	42	29.888	...	...	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ....	...	96.7	72.4	56	29.992	3.92	19	63	N.E.
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	147	72.3	60.3	46	...	1.852	13	73	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

A CASE OF PRURITUS PUDENDI, DUE TO VASCULAR TUMOUR OF THE URETHRA.

By H. MARSHALL FENWICK, M.B., L.R.C.P.,
M.R.C.S., ENG., OF CARLTON, MELBOURNE.

In practice, one is continually meeting with cases illustrating the truth of the old aphorism, "Remove the cause, and the effect will cease."

In no class of cases is this truth more often brought before one's mind, than in the treatment of diseases of the female genital organs; and, as in many of these cases, both the predisposing and exciting causes are often difficult to discover, so the hope of effecting a definite cure must often be despaired of—mere empirical treatment failing to prove of service here, as elsewhere, unless the cause of the malady be first discovered and dealt with.

Of the more common complaints among women, vulval and pudendal pruritus is one of the most distressing and one of the most intractable to treatment. Although a great number of causes of pruritus are enumerated in the various text books, as often as not no assignable cause can be discovered to account for the malady; and this fact probably gave rise to the statement of a great authority on the subject, that "the treatment of pruritus vulvæ et vaginæ is often wholly ineffectual."

Even if we are satisfied as to the cause of the malady, yet we are often unable to explain physiologically, the relation between the affection and its supposed cause; and there can be little doubt that many very dissimilar conditions are grouped under this one head.

I here propose to give a brief account of a case of pruritus due to an unusual cause, the remembrance of which it is hoped will aid in the elucidation of cases of this complaint, the cause of which

may not be patent. The case well illustrates the relation of cause and effect.

CASE.—Mrs. W., æt. 42, consulted me for the first time early in February, 1884. She was complaining of almost intolerable itching and burning pain in the "fore-parts," and had been doing so for more than two years. The itching, which had originally been confined to the vulva, had gradually extended back to the anus, down the inside of the thighs, across the groins, and was beginning to affect the lower part of the abdominal wall. The itching was not constant, but used to come on at irregular intervals, in paroxysms lasting from a few minutes to several hours. One of these paroxysms was always induced by warmth in bed, by exertion, and by marital intercourse; and the attacks were always worse just before, during, and immediately after menstruation, and in warm weather. During the paroxysms, the condition of the patient was almost unbearable. It was impossible to resist scratching and rubbing the parts whilst the itching continued, but this only served to aggravate the discomfort, for when the itching ceased, a tingling, burning sensation remained in the parts which had been most irritated by scratching.

The patient said she had lost a great deal of flesh; was quite unable to sleep at night; suffered from great depression of spirits and irritability of temper; and latterly, so much nervous disturbance had been produced, as to give her friends grave cause for fearing that her mind would give way.

Having eliminated the usual causes of pruritus—leucorrhœa, uterine cancerous discharge, diabetes, hydrorrhœa, uterine displacements, ovarian disease, tea, morphia, or alcoholic tipping, pediculi ascarides—I fancied I could detect an urinous odour about the patient, and, on being questioned, she acknowledged being troubled with frequent calls to micturate, scalding pain during the act, and dribbling away of urine if the first desire to empty the bladder were not immediately gratified. Upon examination, I discovered a small, sessile, vascular growth, about the size of a hazel nut, surrounding the lower segment of the meatus urinarius, and extending along the floor of the urethra for a short distance. The little tumour was exceedingly sensitive to the touch, and bled freely on the slightest manipulation.

There was considerable thickening of the whole urethra, which could be easily traced as a firm cord, tender on pressure, running beneath the symphysis pubis. The long standing congestion of the whole urethra, often concomitant with vascular caruncle of the urethra, had evidently

been followed here, as elsewhere, by hypertrophy of the cellular tissue of the urethra. There was a free ichorous discharge from the excrescence, and there could be little doubt that this acrid matter, mingled with urine, was the cause of the pruritus. The labia were hypertrophied, dark coloured and rigid, evidently the objective consequences of frequent intense scratching and rubbing. They were considerably excoriated near their mucous surfaces, and more externally were covered with eczematous patches, which extended half way up the fold of the groin on either side. The eczema did not appear until some time after the itching began to be complained of, and was also evidently the result of the scratching.

Treatment.—The patient having been anaesthetised, the thighs were flexed and the knees separated as widely as possible. The labia being now separated, I dissected out that part of the excrescence which affected the urethral lips, cutting well beyond the base of the growth. I was then enabled to dilate the urethra sufficiently, with a pair of dressing forceps, to remove that portion of the growth which encroached on the urethral canal. The raw surfaces were then lightly touched with Paquelin's cautery, partly with the object of arresting the hæmorrhage, which was rather copious; and partly with the object of obviating the return of the growth. The tissues of the posterior urethral wall were so vascular and hypertrophied, that I deemed it necessary to destroy the deep tissues below, so as to cut off the supply of blood to the surface of the urethra. This was done by passing the incandescent needle deeply beneath and parallel with the urethra, but without interfering with its mucous membrane. A soft catheter was then passed into the bladder, and was left in for a week. After this period, it was passed at intervals, for a short time, to obviate undue contraction of the urethra. A liniment of chloroform and almond oil, 40 minims ad 3i, was ordered to allay the sense of itching and burning. This it did effectually. After the removal of the catheter, there was incontinence of urine for a few days; but the power of retention gradually returned, and was complete three weeks after the operation. Shortly after this time too, the pruritus and eczema had completely disappeared. Six months afterwards the patient called to see me. There were then no signs of return of the growth, and the itching had never been complained of again.

Since writing the above notes I have seen three other cases of a similar nature; one patient a girl of twelve, one a young woman of eighteen, and the third an elderly lady. In each case a similar plan of treatment to that related above was adopted, and in each case the result was equally satisfactory.

PAROTITIS, DOUBLE ORCHITIS, HYDROCELE OF TUNICA VAGINALIS.

By BERNARD JAMES NEWMARCH, L.R.C.P.,
LOND., M.R.C.S.E., SURGEON TO THE
HAWKESBURY HOSPITAL, WINDSOR, N.S.W.

On January 1st, 1884, I was called to see B.H., ætat 43, who afforded the following interesting history. On December 25th previous he felt a slight pain and noticed a swelling over his right parotid region, this was tender; but after a few hours both pain and swelling passed away. That same evening he felt a pain in his left testicle; the organ enlarged considerably and caused a dragging sensation in his loins. He bore his trouble, however, and never mentioned the fact, though I was at that very time attending one of his children for an affection of the knee joint, apparently rheumatic. The same child was convalescing from an attack of mumps, and the other children in the house had also suffered from the same complaint.

His personal history showed that he was a married man, farmer by occupation, steady, sober habits, and had never suffered from any venereal complaint; had suffered off and on with "slight rheumatic pains" in his joints. There was a history of slight injury to the same testicle from a squeeze, many years ago, when a lad. No difficulty in micturition had ever occurred.

When I saw him he was lying in bed suffering great agony; the left scrotum was much swollen, the skin red and the veins turgid; there was considerable tenderness on manipulation; both the body of the testis and the epididymis could be felt enlarged and hardened; the testicle could be easily distinguished, but was surrounded by a soft fluctuating transparent sac; the cord was not enlarged; tongue furred and dry; bowels constipated; temperature, 101.4; pulse 108, full and hard; no urethral discharge; no difficulty in micturition. The diagnosis was obvious. The treatment simple: rest absolute, saline purgatives, belladonna fomentations, and fluid diet.

On January 2nd the swelling of the left scrotum was the same; pain lessened; urine high coloured, loaded with lithates, and contained some mucus.

On January 3rd.—Passed a bad night; delirious, trying to get out of bed. The right testis was now painful and enlarged, but there was no distension of the tunica vaginalis on that side. The pain in the left testicle had decreased, though the swelling seemed greater. Temperature, 101.2; pulse, 96. Ordered a mixture of tincture of hyoscyamus and nitrate of potash; fomentations to be continued, and a draught con-

taining bromide of potassium and chloral hydrate at night-time.

The following day he was much better, and in a few days he so far recovered to return to work, but a painless swelling still continued on the left side, and four weeks afterwards he applied to me and submitted to the operation of tapping, when nine ounces of clear straw-coloured fluid was withdrawn. Some months afterwards I questioned him and he assured me he was quite well.

REMARKS.—The case is interesting from its history alone. The facts stand out clear that there was a distinct source of infection, and that he did suffer, if only for a few hours, from an affection of the parotid region. He never showed the slightest symptom of urethral discharge.

Dr. Humphry, in his article in "Holmes' System of Surgery," brings forward cases to support the view that parotitis and orchitis, when occurring together, "are different localised manifestations of one pyrexial condition," and this case would apparently uphold that view. Kocher's view that orchitis following parotitis is an urethral orchitis is certainly not shown in this case; there was never any difficulty in micturition or pain during the act, nor discharge of any sort at any time. My own experience in hospital practice is that though certainly the urethral discharge in orchitis following gonorrhœa, which I take it is the disease *par excellence* as example of urethral orchitis, abates on the appearance of the orchitis, still there is always an indication of the "fons," if not "origo mali," and sooner or later the discharge will appear. The hydrocele, in this case, was limited to the left side, and has showed no signs of recurrence after tapping—to my own surprise it must be stated—for it continued long enough to indicate that absorption would not readily take place, and indeed an increase of swelling led my patient to seek further relief.

I was sorely tempted to tap the hydrocele at the first instance, but I doubt whether it would have set at rest the vexed question of puncture of the testis, so called, as a proper mode of treatment of acute orchitis, for the sac seemed hardly distended enough to cause such acute pain, and the right side was equally painful, though the tunica vaginalis on that side was not distended. I have seen immediate relief afforded by the operation, and have practised it effectually, if by the term "puncture of the testis" is meant evacuation of the tunica vaginalis.

I should mention that there has been no apparent atrophy of either testicle.

Mention is made in the article I have above quoted of the supervention of orchitis in cases of typhoid fever. It would be interesting to know if such complication has been observed in this colony where typhoid fever is so rife.

HEREDITY IN THE COLOUR OF THE EYES IN THE HUMAN RACE.*

M. ALPHONSE DE CANDOLLE has contributed to the Archives des Sciences Physiques et Naturelles a treatise on the above subject. "When," says he, "the physical, moral, or intellectual characters are grouped, they behave in the same manner, but one given character more than another may be transmitted rather by the father or by the mother." De Candolle has taken the colour of the eyes as easily marked and ascertainable. Generally we distinguish only black eyes, which must be denominated brown, blue eyes, grey-blue, or grey, when more closely examined. Some brown eyes are yellowish, greenish, or present a peculiar blue reflection, but generally the two categories are easily distinguished. It is interesting to know if they are transmitted from one generation to another, especially when the parents have eyes of different colours. De Candolle finds that women oftener than men have brown eyes. This he thinks strange, as their skins (generally fairer than men's) more readily become darkened by exposure to the sun. Women, however, protect themselves more from the heat of the sun. In 1552 males of different countries, 45·1 per cent. had brown eyes, and in 1418 females, 49·1 per cent. had brown eyes. According to Dr. Guillaume, of 544 boys, 36·5 per cent., and of 661 girls, 38·2 per cent. had brown eyes. In Switzerland, the proportion of brown eyes was in boys 39·2 per cent., and in girls 41·3 per cent. When both parents (con-colores) had brown eyes, 80 per cent. of the children had the same, and only 20 per cent. formed the exception. In that part of Switzerland where French is the language, and where brown eyes are very numerous, the exceptional individuals are 19·5 per cent., while in the country of the German language, where brown eyes are rare, the exceptions are greater—23·4 per cent. Of 357 individuals of different countries, whose both parents had blue, grey-blue, or grey eyes, 334 had eyes of the same colour as their parents, and only 23, that is, 6·4 per cent. had brown eyes. In this category the exceptions rose to 12 per cent. in French Switzerland, where brown eyes are not rare, whilst they did not exceed 4 per cent. in the German part, where the majority have blue, grey-blue, or grey eyes. The reason will be presently explained. Of 578 cases observed, the parents of whom were "con-colores," 88·4 per cent. had eyes like those of their parents, and only 11·6

* For this abstract from the essay of M. Alf. de Candolle we are indebted to Mr. James T. Rudall, F.R.C.S., Eng., of Melbourne, who at the special request of Baron Von Mueller, K.C.M.G., &c., &c., to whom the essay was sent by the author, made the necessary translation for the A. M. G., which will be, we are sure, most interesting to our readers. M. de Candolle has evidently devoted much time and talent to the elaboration of his work.—ED. A. M. G.

per cent. unlike. No doubt the difference of colour of a child from that of its parents may arise from an unknown personal cause, but it is always more likely that it belongs to the influence of a grandfather or grandmother, on the father's or mother's side, or of a more remote ancestor, which is much more rare. In the case of seven persons of Geneva, in whom the colour was different from that of the parents, M. de Candolle has been able to trace it back to the preceding generation. It was found that four of them had their paternal grandmother and two their maternal grandfather with eyes of the same colour. The facts become more interesting when one parent has eyes of one colour and the other parent eyes of another colour. The children must necessarily have the eyes of the father or of the mother, and it is remarkable to see what is the result of this contest between two influences. Of 486 children of fathers with brown eyes, 261, or 53.9 per cent., had eyes of the same colour. Of 630 children of mothers with brown eyes, 356, or 55.9 per cent., had eyes of the same colour. Of 1116 children whose fathers and mothers had eyes of different colours (*bi-colores*), 617, or 55.3 per cent., had brown eyes. From generation to generation the proportion of brown eyes increases; and consequently that of blue eyes diminishes. De Candolle gives some statistics of marriages in Switzerland, from which it appears that, although there is a tendency to the selection of partners with eyes of opposite colour, still, on the whole, the brown eyes tend to predominate in marriage beyond their percentage in the population. From this and other causes, he considers that there is a constant augmentation in the percentage of brown eyes. After having shown that "*les unions bicolors*" are favourable to the health of the populations, he observes, "it is, however, necessary to remember that, according to some facts collected by Mr. Francis Galton, confirmed by my new researches on Heredity, the question is less clear as to that which concerns the characters of instinct, feeling, and intelligence. Men who are successful in their career appear to spring from parents, like, rather than unlike. Similitude brings to the children a greater intensity of the characters which profit in social struggles; but this advantage is sometimes destroyed by defective health or by the exaggeration of hurtful qualities. De Candolle states, on the authority of Wartmann (though he doubts the sufficiency of the statistics), that Daltonism—colour-blindness—proceeds almost always from the father or grandfather; sometimes the mothers transmit it without being themselves the subjects of it. At Stockholm, M. Wittrock saw a father having one eye blue and the other brown; but the peculiarity was not reproduced in either of his

two children. He also saw two mothers who had each one blue and one brown eye, but neither of their three children presented a similar anomaly. Horner, of Zurich, has mentioned the frequent heredity of reddish spots on a blue iris, and the fact has also been observed by ourselves.

CASE OF PHTHISIS, FOLLOWED BY EMPYEMA, TREATED BY FREE INCISION—COLLAPSE OF LUNG—RECOVERY.

UNDER THE CARE OF A. SHEWEN, M.D. LOND.,
HON. PHYSICIAN TO PRINCE ALFRED HOSPITAL, SYDNEY.

P.M., labourer, aged 23, was admitted into Prince Alfred Hosp. on 5th March, 1884. Had been ailing for five months with cough, night sweats, &c. No family history of phthisis.

On admission, it was found that the left infra-clavicular region was dull on percussion, with bronchial breathing, and the hospital notes say he presented all the signs of a cavity at the left apex.

March 21.—To-day there is absolute dullness all over left side, with diminished expansion, vocal fremitus absent, respiratory murmur gone, and the heart is pushed to right. Thirty-eight oz. pus removed by aspirator.

28.—Seventeen oz. pus aspirated.

Up to this date, the patient was under the care of Dr. Chambers, to whom I am indebted for the case.

May 2.—Absolute dullness over whole of left side, except immediately below clavicle; no expansion, but bulging of intercostal spaces, no vocal fremitus, great tenderness on percussion, heart displaced to right.

Dr. Skirving made a free opening in the sixth intercostal space, rather behind mid-axillary line; a great quantity of pus was evacuated, and the cavity well washed out.

May 3.—The cavity was washed out three times to-day.

From this date to the 16th of June, the patient made rapid progress; his weight increased, his temperature was normal, and his appetite good, but, on the day mentioned, he got suddenly and intensely cyanosed, accompanied by great collapse and dyspnoea; at the same time, his temperature rose to 103 deg. The hospital notes taken on the 17th say that loud bronchial or cavernous breathing, with metallic tinkling, is distinctly heard at left base. The same is heard, but not so distinctly, in left axilla and over cardiac area. Heart's sounds most distinctly heard to right of sternum. The chest was washed out with a lotion of quinine, but no taste in the mouth was observed, nor was

there any irritation from the injection. The chest held a large amount of fluid. We were at a loss to understand this sudden rise of temperature, for the patient had been doing remarkably well. On the 23rd June, the temperature still running up to 102 deg., I examined the chest with a long probe, 10 or 12 in. in length, and then I found that the chest cavity was almost completely empty and the lung collapsed. The probe could be moved about freely from base to apex without meeting with any obstruction, and the point of the probe could be laid on the heart as it beat within the pericardium. With this state of things, I think we were justified in believing that the rise of temperature was due to some sudden collapse of the lung. Be that as it may, in a few days the temperature fell to the normal once more, and never again rose. The cavity of the chest began to hold less fluid, the respiratory murmur began to re-establish itself, the patient's appetite returned, he gained in flesh and spirits, and, on the 22nd July, he was sent to Little Bay Hospital, the wound in the chest having nearly closed up, and little or no fluid could be injected.

On the 17th November, I saw him in my consulting room. He has been at work gardening for a month past; he feels able to work, but gets a pain in side on stooping. Appetite good, sleeps well, has had no cough for two months. When examined, he was found to be in good condition; left shoulder lower than right, marked deformity of left chest, left expanded less than right, heart's apex normal. Resonance, front, good to axillary fold, then gradually lessens till it almost disappears at lower axilla. Resonance, back, good, almost equal to right. Vocal fremitus, front, disappears at axillary fold; back, fair all over. Respiration, front, good, except in axilla, where it is very faint; behind, good, but at extreme base some moist crepitation. Respiration is normal in tone everywhere; cyrtometric measurement as shewn; heart's sounds normal.

Remarks.—To me this has been a most interesting case, and I should like to ask the opinion of my medical friends with regard to the question as to how the lung manages to re-expand itself after it has been so completely collapsed as it appeared to be in this case. I find it very difficult to explain to myself how an elastic bag, like the lung, can re-open itself within a cavity which has free communication with the external air. I must say that, when I found this man's pleural cavity pretty well empty, I did not anticipate that the lung would re-expand and once more fill up that cavity as it has done. But not only did it do so, but it filled up quickly, so that, day by day, less fluid could be injected when the cavity was washed out. Another very interesting and important

point which this case gives rise to is, whether we did really cure a cavity of the lung by allowing that organ to collapse and re-expand. I believe it has been suggested as a cure for unilateral phthisis that the cavity of the pleura be opened and the lung be allowed to collapse, but I have not had an opportunity of trying the experiment in an uncomplicated case. I am inclined to believe, however, that this is a case in point, and I shall be anxiously on the look-out for an undoubted case of phthisis, accompanied with empyema.

EXCISION OF KNEE JOINT — RECOVERY:

By H. V. DREW, M.R.C.S.E., RESIDENT
SURGEON TIMARU HOSPITAL, NEW ZEALAND.

J. F., admitted into Timaru Hospital, was the only survivor of a family of seven, and though I cannot ascertain the cause of death in these cases, there was beyond doubt a tubercular tendency.

Two years ago patient had a fall from a horse, and ever since suffered off and on with pain in the knee. Six weeks ago he again struck the knee, which swelled up and became intensely painful; an abscess formed in front of the patella, which was opened by the practitioner attending him, when half a pint of pus escaped. This went on discharging, and on admission I found an ulcer over the patella the size of a crown piece and one or two superficial sinuses; and upon examination with a probe a small aperture was discovered through the patella; there was no other opening communicating with the knee joint.

He was under observation for some days, but as his health was failing, and he was sweating profusely at night, on the 5th November, 1884, I, after consulting with the other gentlemen in practice here, decided to excise the knee joint.

His evening temperature before the operation was 102° F.

Upon opening the joint by a transverse incision, and turning up the patella the under surface was found to be extensively necrosed; it was accordingly removed. The synovial membrane had undergone the usual degeneration; the cartilages were commencing to go, and the ligaments all softened.

The patient recovered without a bad symptom, except severe vomiting for twenty-four hours after the operation, but this ceased upon my procuring some ice.

I used the ordinary bracketed splint and the method adopted by Dr. Hayes, viz., a well-

padded short splint over the anterior surface of the thigh, buckled by three tapes, which kept the femur immovably fixed upon the back splint. Instead of a slide behind the knee, I used a piece of thick cardboard, padded, and adapted to the back of the knee by three tapes and buckles, fastened from bracket to bracket. I think this is an advantage, as it does not give and is perfectly comfortable.

Antiseptic dressings (Lister's) were used, not a drop of pus was formed after the operation, and the joint was drained by two tubes, one on either side of the limb at the back.

The extraordinary feature in the case is the necrosis commencing on the posterior surface of the patella and working through to the front.

[We regret that our contributor did not enter into fuller particulars as to this very satisfactory case. The account he gives us being of the barest possible description. We publish it as reported, it being a very successful operation, and New Zealand being too far away for us to forward the paper to the author for extensive revision.—ED. *A.M.G.*]

CASE OF INFANTILE ERYSIPELAS.

By R. T. ALLAN, M.D., M.R.C.S.E.,
L.R.C.P. ET L.M., EDIN., &c.,
RAYMOND TERRACE, N.S.W.,

FORTUNATELY the variety of Erysipelas found under the age of six months is rare, but it is rarer still when present in a child of 10 days old.

This was the age of a little female patient brought to me by her grandmother a couple of months since. Instead of starting from the umbilicus (as is most usually the case) the disease commenced at the left nipple, and when first seen formed a red, slightly œdematous swelling, with heat and pain two inches in diameter, with the nipple for the centre of the circle. I painted with Iodine and prescribed inunction of ol. Morrhuæ. The area within, however, gradually spread until the whole of the left side, back, and front was purple and livid and with fluctuation. The grandmother at first refused to allow me to use the knife, but next day consented, and two incisions were made and much pus evacuated. The child began gradually to improve and is now quite well. I could for some time discover no *raison d'être*, but at last I found that the mother of the child, when advanced in pregnancy, and when stepping ashore from a steamer, had tripped and fallen on her left breast, bruising it. Was there any connection between the two? Bouchut says all new born infants, if attacked by erysipelas, die. This one, although almost despaired of, lives and is well.

OPERATION FOR PERINEAL RUPTURE.

(READ BEFORE THE S. A. BRANCH B.M.A.)

By J. C. VERCO, M.D., LOND., F.R.C.S., E.,
B.S. AND L.R.C.P., LOND., &c.,
HON. PHYSICIAN, ADELAIDE HOSPITAL.

THIS operation consists simply in turning up a postero-lateral flap of the vaginal mucous membrane, and bringing the denuded parts together, without removal of any tissue. When the perineum that has been ruptured is examined, there is seen on each side of the now abnormally enlarged vulva a scar. This extends from the point where the fourchette of the vulva was originally, backwards and slightly outwards, as far as the anus. This scar marks the line along which the two sides of the perineum were formerly united, and shows the extent outwards to which the parts should be denuded, in order that they may be brought together into exactly the same position that they occupied before the rupture occurred.

Enter the knife at the anterior extremity of this scar, carry it out and back to the furthest limit of it, then across the septum between the vulva and the rectum and up along the other side of the perineum to a point corresponding with that at which the knife was entered. Dissect this flap upwards toward the vagina from behind. Let it be raised along the vaginal septum as high as the rupture scar extends, or about an inch to an inch and a half, if there is no such guide, and at the sides be so dissected up that the bare surface comes to a point at the spot where the knife was first entered. There will then exist one large fleshed surface, which may be regarded as two triangular surfaces hinged along the middle of the recto-vaginal septum, and these are brought together by the wire sutures in the ordinary way. The posterior two should be stout ones, the others thin, the first being entered about three-quarters of an inch outside the margin of the anus, and on a level with the anal aperture. It should be carried along in the substance of the recto-vaginal septum, above the limit of the vaginal flap, so that it does not appear anywhere in the wound. The others are seen. They are simply ordinary interrupted sutures. The vaginal flap is left alone. It really needs no paring and no adjustment; it folds longitudinally in the vagina and unites with the new perineum. The bowels are kept confined till two or three days after the sutures have been removed. The patient may pass her water when she requires to by turning on her face. A sponge then applied to the vulva will prevent any dribbling of urine back into the

wound. The wound itself I have dressed with nothing. No. T bandage is applied, and no lint, and so there is nothing to catch in the twisted ends of the sutures and disturb them.

The cases thus operated on by me completely healed throughout. One of them was complicated by a recto-vaginal fistula about two inches up, which was operated on at the same time as the perineum. The perineal sutures were removed on the tenth day, those for the recto-vaginal fistula on the fourteenth.

This operation commends itself for several reasons. First, if it succeeds (as the incisions follow the line of scar), the perineum must be of just the same extent as before the rupture, neither longer nor shorter, wider nor narrower; for the original injury was only a tear; there was no destruction of tissue, and rationally the treatment should be, just to bring into apposition again the parts that were in apposition before.

In the next place, if it should fail, nothing has been removed, and after the healing of the wounds the patient is as well off as she was before the operation was undertaken.

Lastly, the vaginal flap protects the wound from irritation by vaginal discharges, and maintaining its vitality in virtue of its wide attachment it folds on itself longitudinally, increases considerably the thickness of the perineum, and gives to the examining finger the same impression as is derived from a nullipara.

Though this has been written down "a new operation," it is a very old one. In the October number of the *British Medical Journal*, 1884, it is mentioned as being introduced into Manchester by Ewart, and as being described by Jonathan Hutchinson, in "Holmes' System of Surgery"—this was some fourteen years ago—and Hutchinson gives it as a slight modification of an operation by Fricke. It is therefore respectable by reason of its age, and instead of having novelty to commend it, it has what is far better, an evident reason in its plan, an extreme simplicity in its performance, and an abundant success in its results.

I may further state that the troubles for which the operation was undertaken have almost wholly disappeared. One patient is now advanced in pregnancy. Yesterday I delivered another of a healthy, full-time child. In this case, on examining the perineum, it would have been impossible to detect that a rent had ever existed, or an operation been performed. It resembled the perineum of a nullipara, and yet it was the case that was complicated with the recto-vaginal fistula. The labour was difficult, the head being caught in the upper part of the pelvis, and, much against my will, I had to apply the forceps, and

bring it down into the lower part of the pelvis. Then I removed them and allowed the labour to continue spontaneously. It was exactly like a primipara, tedious, and with the formation of a caput succedaneum. The perineum gave way, but not into the rectum, as before, but for about half an inch from before backwards as the head came through the vulva, just as in a first labour. I have no doubt that this will unite completely, or almost so, but to whatever extent this slight rent may heal, the new perineum has stood the test.

Mr. Hayward remarked that it was somewhat difficult to follow the details of the operation suggested by Dr. Verco without the aid of a diagram, but he gathered from the description given that its chief value laid in the fact that no tissue was removed—a point of extreme importance, especially in cases that had been previously operated upon. He took the opportunity of drawing the attention of the members to the modification of Professor Simpson's operation, described by Drs. Hart and Barbour in their "Manual of Gynecology." He had lately performed it in the Hospital, with a very gratifying result. In his case he had allowed the bowels to remain constipated for three weeks without any untoward result to the patient, but before allowing them to be moved, he had caused a large injection to be administered, and the collected fæces to be broken down by means of a long tube.

CASE OF MULTIPLE SARCOMA.

(UNDER THE CARE OF DRs. STIRLING AND CORBIN.)
REPORTED BY BENJ. POULTON, M.D. ET CH.B.,
MELB., M.R.C.S.E., JUN. HOUSE SURGEON,
ADELAIDE HOSPITAL, S.A.

THE patient, aged 29, was first admitted February, 1883, stating that four years ago a tumour, the size of a nut and on the site of a mole, was removed by operation from the left instep by the late Dr. Gosse, the operation being strangulation by a silken ligature. In two years a tumour reappeared on the same spot, and after about nine months interval others appeared. Has been losing flesh lately, and during the last four or five months there has been a rapid growth of tumours in the left leg and thigh and the appearance of others in the neck. A month ago a poultice was applied to the tumour on the instep, and soon after it broke. On admission there were at least six nodulated projecting tumours on the left leg and thigh and two in the neck. The one on the instep is fungating. There was no family history

of malignant disease. The patient complained soon after admission of shooting pains from the foot to the head and of sleeplessness. Dr. Stirling removed the ulcerating tumour of the instep, and found it black and soft, with outgrowth undermining the skin for some distance. Hare-lip pins failed to approximate the skin edges closely. A small separate tumour was removed from the base of the little toe. The wound healed but slowly, and cicatrization had to be aided by the use of skin grafts. On May 12th she was discharged, with a firm but broad cicatrice, and much relieved by the absence of the fungating mass. The other tumours continued to grow slowly.

On September 26th, 1883, the patient was readmitted, with a large fungating tumour of the inner aspect of the left thigh, which did not bleed nor discharge. The tumours of the left leg were all grown larger.

On October 3rd all the tumours were removed from the leg and thigh, the dissection required for their enucleation being very extensive, and many vessels required ligation. Each tumour was juicy, and most of them melanotic in a marked degree. Grafting was again resorted to, in order to facilitate cicatrization. On October 31st two glandular enlargements were removed from the left thigh, one from the right arm, and two from the neck. On November 19th all the granulating surfaces at sites of operations were healthy-looking and healing, and six subcutaneous tumours, varying in size from a pea to a large bean, were discovered in the dorsal integuments. The skin over them not discoloured, the patient previously unaware of their existence.

On December 21st the patient was discharged, and did not again appear until June 11th, 1884, when it was found that the six tumours noted previously on the back were all larger, that two small ones had developed on the right arm, one small one on the right forearm, another on the posterior fold of the left axilla, and two on the left leg. The general health was very indifferent, the nutrition bad, and the patient complained of pains in her bones. All old cicatrices healthy, except a small one on the thigh, which has a bean-like tumour under it, and there was still a granulating surface on the leg. On June 18th the tumours of the back were all removed. On July 16th nine more tumours were removed from the limbs and back, and on September 5th she was sent to the Convalescent Hospital, there being still one tumour on the ulnar side of the right forearm. Her next final admission was January 3rd, 1885, the patient this time asking relief for severe abdominal pains, obstinate constipation, and tendency to emesis. She is thin,

haggard, and very anæmic. There are many small sarcomata under the abdominal and thoracic integuments. The urine was found to be alkaline and to deposit phosphates; it contained no albumen. The constipation was only relieved by repeated doses of cascara sagrada. Her general condition did not improve, and until her death, on February 13th, her frequent vomiting, emaciated appearance, and paroxysms of abdominal pain, were painful to witness, but were relieved in some degree by frequent and large doses of morphia internally and hypodermically. The post-mortem revealed the growths shown, one adherent to the right auricle, the others in close proximity to the kidneys.

NOTES ON THE DRESSING OF WOUNDS BY THE DRY METHOD.

BY CHARLES SWANSTON, L.R.C.P. AND S.,
EDIN., SURGEON TO THE MUDGE HOSPITAL,
N.S.W.

My object in writing the following is to advocate the use of "dry dressings;" the material used is 10 per cent. iodoform wool. As the subsequent treatment of wounds made in operations is second only to the judgment required in the decision for operating, very much attention has been drawn to it of late years. The spray and complicated dressings of "Lister's antiseptic method" are almost impracticable in up-country practice, and I think the following cases will show that wounds can be dressed without one tithe the trouble attached to it, and that the results are equally good. The instruments, sponges, &c., are thoroughly soaked in (1-40) solution of carbolic acid, and the cut surface cleaned with same solution, then the iodoform wool applied, and *allowed to remain until the wound has completely healed.*

I.—A. B. A fibro-cartilaginous tumour, situated on right side over fifth rib, about size of a small orange. An incision, six inches long, was required to extirpate the mass. The wound was stitched, then iodoform wool applied. The patient was up next day. He went home from hospital on third day, and returned at the end of a week, when the dressings were removed. Union by first intention.

II.—Mrs. H. Admitted into hospital with a large fungating encephaloid mass, involving left breast and pectoralis major. The incisions required for its removal were so extensive that the edges could not be approximated nearer than an inch, so prepared sponge was inserted and the wound stitched up; no drainage tube; iodoform dressing. I was rather anxious about this case, and took off the dressing on the third day, as the tem-

perature was slightly raised—100deg. The wound was healing well, and everything looked healthy, no discharge whatever, and accordingly I re-applied the dressings. This was followed by some restlessness during the night, but I did not remove the bandages till a week had elapsed. The wound healed by granulations; no offensive odour could be detected, but a small amount of healthy pus on removal of dressings. This was mopped up with iodoform wool, and fresh dressing applied, the patient being allowed to get up.

III.—Mrs. N. This was a patient I saw in conjunction with my colleague, Dr. Graham. A lipomatous tumour, about the size and shape of a "shut fist," formed on the pectoralis major, and extended from the upper border of axilla upwards and inwards to about half an inch above the clavicle. Although the tumour was soft, it was causing paralysis of the arm from pressure. An incision, four inches long, was sufficient to turn out the tumour. The edges were brought together, carbollised catgut ligatures used, and iodoform dressing. This was not changed until the tenth day, and when the bandages were taken off the wound had healed.

IV.—J. F., æt. 55. Admitted into hospital with a history of suppuration from knee-joint of some years standing. He was gradually sinking from exhaustion. The disease had evidently involved the end of the femur, as it was enlarged. I amputated, by Teale's method, in the middle third of thigh. This gave a cut surface of seventy-eight square inches; no drainage-tube; dry iodoform dressings. Next morning the patient was able to sit up in bed and enjoy his breakfast. Dressing not changed for ten days, at expiration of which I was able to take out the stitches and allow the man to get up. There was neither discharge nor rise of temperature, except on the first night, when it went up to 99 deg.

V.—J. C. Extensive wound of palmar arch. As the hæmorrhage could not be controlled by the ordinary method of bandaging, an Esmarch had to be put on, the wound opened up, and three arteries tied with difficulty. This stopped the bleeding at once, but left a large rugged wound. Iodoform dressing was applied, and the man told to come back that day week, when the wound had healed.

I select the above cases, as they occurred recently. Before I had complete faith in dry dressing, I used to examine the wounds more often, but never had such satisfactory results—in fact, the best cases were those that went home and did not come back for a week. In conclusion, I need scarcely point out the advantage of this method to those who have to work single-handed in the bush.

ASSOCIATION INTELLIGENCE.

VICTORIAN BRANCH.

ORDINARY MONTHLY MEETING.

Melbourne, Wednesday, February 18th.

The President (Mr. Rudall) in the chair.

NEW MEMBERS.

The Honorary Secretary announced the election by the Council of Dr. Marchbank, of Terang, and Dr. Owen, of South Melbourne.

The PRESIDENT then requested Dr. McMillan to occupy the chair while he read the following paper:—

TWO CASES OF HERNIOTOMY.

By JAMES T. RUDALL, F.R.C.S.E.

CASES of strangulated hernia are of sufficient frequency and intrinsic importance to interest all of us as practitioners, and I therefore venture to bring under your notice the following two cases, which occurred in my practice a few months ago.

On the afternoon of July 17, 1884, a message was sent by my friend, Dr. H. Macmullen, requesting me to meet him in consultation, some miles from Melbourne, on a case of strangulated hernia. The rupture, which had existed from childhood, became strangulated early in the morning, and Dr. Macmullen having made a thorough trial with the taxis, under chloroform, without result, dispatched a messenger to me. I found, on making an examination, that our patient was a strong man, of about thirty years of age, with a tightly strangulated, oblique, right inguinal hernia.

Dr. Macmullen administered chloroform, and as the taxis failed also in my hands, I aspirated the hernia, but without effecting reduction. I then cut down in the usual manner and found that the stricture was very deep in the neck of the sac. The sac was opened, and the intestine was found to be of a dark claret colour, the stricture was divided and the bowel returned into the abdomen. The wound was closed with a few sutures, except at its lower angle, well powdered over with iodoform, and a large compress of wool and a flannel bandage were then put on.

On July 20th he had had no bad symptom, and apparently no feverish condition, but the bowels had not acted; he had not vomited since the operation. He complained only of hunger.

Two of the sutures were taken out; wound quite healthy and healing.

In two or three weeks he called on me, and the wound being quite healed, he was fitted with a truss.

In this case the modified antisepticism, which it has been my custom to employ for more than a year past, was found very convenient and efficient. It consists in the use of sublimate solution $\frac{1}{10}$ per cent., and common salt $\frac{1}{2}$ per cent., supplemented according to circumstances with iodoform, salicylic acid, or eucalyptus (powder, wool, gauze, &c.)

The next case presented very unfavourable conditions. The patient was insane, and was otherwise a bad subject for any operation. The time of the occurrence of strangulation of the long-existing rupture was not precisely known, but immediately on its discovery every reasonable effort was made to reduce it by the taxis, without success. Therefore, when I saw him on July 19, 1884, as soon as he was put under chloroform, I proceeded immediately to operate. The rupture was rather large, and was a left oblique inguinal. On exposing the intestine, and passing my finger into the inguinal canal, I could find no stricture, but on exploring downwards I discovered the stricture below the termination of the incision through the skin. With the hernia knife the superficial parts were laid open downwards and the stricture divided. The intestine had been very tightly constricted by the sac itself. The bowel was of a dark brown red, with spots of deeper colour; it was coated with lymph, and its walls were much thickened. There was great difficulty in returning it into the abdomen, although the way was quite free, but by raising the patient's hips it was at length got back. One vessel was tied in the early part of the operation, the upper part only of the wound was closed by four sutures. Iodoform and eucalyptus dressings were applied.

The patient died within 48 hours from peritonitis, a result which we all anticipated, but the bowel was everywhere free, as was proved by the post-mortem examination.

It is a general and well-founded belief that the operation for strangulated hernia, is, as a rule, very successful if it is done not long after the occurrence of strangulation and before local inflammatory changes are set up. In the first case reported above, although the stricture was tight, the bowel below it was merely congested, and the favourable prognostication of my colleague and myself was confirmed by the result. In the second case the conditions were unfavourable and some

of them unusual. How came the stricture to be situated low down in the body of the hernial sac? It is not easy to see what should cause the sac to tighten itself in a circumferential line and constrict its contents. The explanation I have to suggest is, that the stricture was the original neck of the sac, which had been pushed down, and had ultimately caused strangulation by more bowel being thrust into it. The great difficulty in reducing the intestine after division of the stricture, and after making sure that it was free from all adhesions and that the inguinal canal was patent, must of course be mainly referred to mechanical or dynamic conditions of the abdomen itself. In regard to this, one would like to know whether the hernia had been irreducible, and if so, for what length of time; but the circumstances of the case were such as to preclude our obtaining accurate information on these and several other points. The idea of leaving the inflamed intestine (after dividing the stricture) outside the abdomen did indeed pass through my mind, but it appeared especially undesirable to do this in an insane patient. Although not prepared to declare that I would do it in every case, I am strongly in favour of opening the sac, as a rule, umbilical hernia, of course, excepted.

"In reply to Dr. Henry, Mr. Rudall said the strangulation in the first case took place on the same day. We employed common salt in the antiseptic sublimate solution, because he did not wish the solution to dialyse too much. It was very unirritating. The proportion of sublimate was not too strong. The iodoform produced no toxic symptoms. It was, however, an agent to be used with caution to fresh wounds. The formula for the solution was:

B. Hydrarg. Perchlor., gr. iv.
Sodii Chloridi, 3 ij.
Aqua ad., 3 ij.

In Lister's form the sublimate was used with albumen. The one he (Mr. Rudall) used could be applied to the most delicate membranes, the eye, for example, with safety.

Dr. McMILLAN added his testimony to the value of iodoform as an antiseptic.

THE MELBOURNE DISTRICT NURSING SOCIETY.

Dr. HENRY drew attention to the recent formation in Melbourne of a District Nursing Society, and dwelt upon the value of such an institution as an important adjunct to medical treatment. The society in London had proved of signal service, and as it had been found that the mortality even in poorly furnished homes was considerably less than in the best hospitals, he thought the profession here should give the movement their support.

The PRESIDENT said, in instituting comparisons between cases treated at home and in hospital, it was necessary to assume that the cases were of parallel severity. It might be that those in hospital were of a graver nature than those in homes.

Dr. SPRINGTHORPE said that the Melbourne hospitals were crowded with cases which ought never to have been taken out of their homes.

Dr. McMILLAN regretted the absence of self-respect in the populations of these colonies, whereby the hospitals were crowded in this way.

After some conversation,

The PRESIDENT thought that without the meeting committing itself to any specific resolution, it might be sufficient to say that the principle of a District Nursing Society was one which met the approval of the profession.

The next paper read was

ON SELF-POISONING IN INFANTS.

By LOUIS HENRY, M.D.

THE self-poisoning of infants introduced itself to my notice a short time ago when attending a large number of cases during an epidemic of measles. Some of the worst cases fell into conditions of catarrhal pneumonia with excessive cough and muco-purulent secretion. Some of these cases died, and others, more particularly of an older age, recovered. I, for a long time, was unable to satisfy my mind what might have been the direct cause of death, as the physical examinations during the progress of the cases were not of a character to predetermine the result. There were no physical symptoms of any disease of the lungs. It struck me, as my experience increased, that those cases of similar gravity which were able to expectorate, recovered, and that those who invariably swallowed their sputa, as infants will, succumbed, or died of infective poisoning. We know that in tuberculous degeneration, where the absorption of a softened mass, due to the ulcerative condition of the broken up tissue elements occurs, an effect is demonstrated in the shape of hectic fever, and that the great aim of therapeutists is to neutralise this by disinfectants, drainage, and good nourishment, or improved oxidation. I need say nothing of the specific bacillus which would find a good growing ground in the sputa and fatten and increase on its travels through the system. It was, I believe, thought that the gastric juices were the natural destroyers of any living organisms that ventured into the stomach. But when I remind you of such living organic poisons as echinococci, sarcinæ tæniæ, trichinæ, and typhoid germs, you will agree with me that this healthful theory must explode, and that it is far safer to annihilate these irritative elements before they are permitted to enter the body by way of the mouth.

Thrush is due to cryptogamic vegetation. In the mouth the sporules increase rapidly and form tubular fibrils. The plant forms a nidus in the altered secretions of the mouth. Another kind of

infective poisoning in infants is that due to mal-assimilation. Urea is a powerful neurotic poison, and where its excretion is prevented and where there is also a retrograde metamorphosis of nitrogenous substances we get ferments in the system which produce coma, convulsions, and death. A mass of indigestible food is given to the child, perhaps in a not over clean bottle, to suck and draw. It drinks with rapidity, and, so to say, bolts it. Whatever little saliva there may be in the mouth does not meet the food. The stomach is perhaps abnormally acid, hence the thirst. The result is a curdling of hard unbreakable curd. Acid fermentation sets in, gases rise, sour smelling eructations, pain, colic; limbs are convulsively drawn up, the eyes roll, the face becomes blue and livid, &c.; the action of the kidneys may be suspended. This either ends in convulsions or in emesis and diarrhoea. The coma or vertigo is produced by the irritation of the vagus nerve and the sympathetic. Other irritative or infective processes are caused by excrementitious matter retained in the circulatory system. The natural excretions of the body, when retained, become irritants of a highly acrid character, and there exists a constant condition of mal-assimilation, which keeps up a constant condition of disease, causing a loss of flesh and rendering the little patient languid and pale.

Dr. McMILLAN said he had always observed that young children did not expectorate, and he would be glad to know if it were possible to meet this difficulty.

Dr. SPRINGTHORPE thought an occasional emetic might serve as a partial remedy for the deficiency. Various theories at present prevailed that some of the excretions were toxic in their nature. Urea was an instance.

The PRESIDENT thought there was some doubt as to urea, but other excretions might have a poisonous effect. The juices of the stomach, however, were ordinarily effectual in chemically neutralizing them. In the cases referred to by Dr. Henry he thought it would have been well if post-mortem examination had been resorted to to determine the actual cause of death.

Dr. McMILLAN made some remarks upon

THE TREATMENT OF TYPHOID FEVER.

He said he had not written any paper, but he thought a conversation upon so practical a subject might not be without its value. He summarised the course of an average case. The quality and quantity of diet he regarded as of vital consequence. It should be easy of digestion and nutritious. In the way of medicaments, as there was sometimes constipation, aperients were indicated, but these required to be of the blandest kind. At a later period, when the abdominal symptoms needed continual watching, the quinine treatment should be entered on, and this he regarded as the sheet-anchor in typhoid. Stimulants, he thought, were better avoided for the most part, yet now and then they might be employed with benefit. Antiseptics had their value, such as boracic acid and the salicylate of soda. The cold bath treatment had many advocates, and no doubt

it had much to recommend it, but he thought it ought to be employed with caution, on account of its tendency to lower the heart's action. Moreover, it was often strongly objected to by the friends of patients.

The PRESIDENT referred to the lessening of the mortality in typhoid. Twenty years ago it was 1 in 5. The diagnosis, moreover, was now much clearer, and special dangers were more generally avoided.

Dr. SPRINGTHORPE referred to a remark of Dr. Broadbent, in "Quain's Dictionary of Medicine," in which it was declared to be criminal not to use the cold bath in typhoid.

After some conversation,

The PRESIDENT said he thought it would be well to discuss the whole subject of typhoid, only it would be more advantageous to deal with it sectionally, and especially it was desirous for those who took part in the discussion to speak from experience, bringing evidence from the cases they had seen. This suggestion met with general favour, and measures will be taken to deal with the question on this basis.

ERRATUM.

Mr. RUDALL desired to make the correction of an error which occurred in the correction of his remarks on Dr. Lucas's case in the January *Gazette*. The words "lateral fracture of the spine" had been printed, instead of "latent fracture," where reference was made to Mr. Simon's case.

SOUTH AUSTRALIAN BRANCH.

MONTHLY MEETING.

Held at the Adelaide Hospital, February 26th, 1885.

The President (Dr. C. Gosse) in the chair.

THE President referred to the annoyance and persecution to which the City Health Officer (Dr. Robertson) was at present subjected by some of the members of the City Council. First, they tried to get rid of him; then, failing in this, an attempt was made to lower his salary; and the last indignity was a suggestion that he should not have a seat on the Council Board, but wait in an ante-room until he was wanted. He thought the sympathy of the members was certainly due to Dr. Robertson in his present trying position, the more so because, if Dr. Robertson were to consult his own personal comfort in the matter, he would certainly resign and save himself further annoyance from these unprovoked attacks. But he felt that it was due to the dignity of the profession to which he belonged to contest every point and not allow the office he held to be degraded by any ignorant attacks.

Dr. GORGER thereupon moved, "That this meeting of the S. A. Branch of the British Medical Association expresses its sympathy with Dr. Robertson in his efforts to sustain the dignity of the medical profession, in defending himself from the attacks recently made upon him by the City Council of Adelaide."

Mr. HAYWARD seconded the motion, which was carried unanimously.

EXHIBITS.

Dr. Gardner exhibited a girl, aged 3½, who had recovered from an attack of cancrum oris, giving the following particulars:—

When admitted was a weak, badly-nourished child, whose mother, being in domestic service, had placed her for some time in the care of another person. She is stated to have been ill ever since a recent attack of measles, and was then suffering from cancrum oris of the right cheek. There was a slough of the right cheek,

about the size of a florin, ulcerated on the inner surface, but dry externally. There was much fetid discharge. Two shallow, flat ulcers were on the left cornea.

May 3, three days after admission, the slough was removed by scissors, leaving a cavity exposing the molars of the upper jaw, and showing necrosis of the alveolus and part of the body of the upper jaw. There was no hæmorrhage.

On May 5th the angle of the mouth and one-eighth of the upper lip sloughed away, but she continued to take food well.

By May 16th all sloughs had separated; the edges were now cicatrizing, and two flakes of necrosed bone were removed from alveolus, each about half-inch in length.

On June 3rd discharged in good health, the mouth somewhat drawn to one side.

The treatment consisted of a chlorate and permanganate of potash mouth-wash, chlorate of potash and bark internally, with wine and abundance of light nourishing food.

Dr. Gosse showed a child with pale fleshy granular conjunctivitis, with no corneal complication, in which most marked benefit had resulted from scraping the granulations with a Volkmann's spoon. The palpebral conjunctivæ, especially of the right eye, were now almost quite smooth, and exhibited no trace of injury, notwithstanding the rough treatment.

He also brought forward a man with atrophy of both optic nerves, apparently resulting from an injury to his second cervical vertebra, received about eighteen months previously. Atrophy of the optic nerve being a comparatively rare complication of spinal injuries, it was thought worth while to bring it before the members.

Mr. Dunlop gave a practical demonstration of the ease with which a patient can be taught to wash out his own stomach. The man exhibited was suffering from dilatation of the stomach, supposed to have been caused by eating too freely of potatoes. The treatment with the permanganate of potash washing had already produced a marked benefit.

Mr. Hayward exhibited a case of loco-motor ataxia, in which the patient was suffering from well-marked Charcot's disease of the knee-joint. He stated that the patient had first exhibited ataxic symptoms about five years ago, and that the disease had slowly but steadily progressed from that time. About two years ago, Mr. Hayward's attention had been directed to the patient's left knee-joint, which at that time began to enlarge, and on being moved gave rise to a creaking sound and a similar impression when the hand was placed over it. After a time synovitis developed, and about four months since it became apparent that the ligaments had become stretched. With a view of relieving the excessive tension, the joint was aspirated, and five or six ounces of ordinary synovial effusion removed. This proceeding benefited the patient for a time, but the effusion soon began to accumulate again and shortly afterwards a fluctuating tumour was noticed, which extended from about six inches above the knee to about half way down the calf of the leg. This was aspirated at its lowest point and eight or ten ounces of blood-stained fluid removed, with the effect of completely reducing that part of the tumour situate above the joint, though some fluid remained in the lower segment. The fluid rapidly re-accumulated, and was aspirated on two other occasions, but only partially emptied, as the tube became blocked by broken down tissue. The patient always experienced ease from these operations, more in the direction of increased comfort than relief from pain, for

throughout the disease there had been little or no pain. The present condition was an enlarged knee-joint, which permitted movement in all directions, the leg being capable of dislocation from the thigh both posteriorly and laterally; crepitus was distinct, the cartilages having apparently become absorbed; a large tumour extended from the back of the joint almost to the ankle, with marked fluctuation throughout.

Dr. Gardner exhibited a pair of Gowan's bone-forceps and saw combined; also, Gowan's saw for removing Sayre's jackets, and a pair of Thompson's vesicle tumour forceps.

Dr. Lendon exhibited a probang for removing membrane from the trachea after tracheotomy. The instrument is depicted in the *British Medical Journal*, of January 17th, 1885, and is the joint design of Messrs. Macintire and Bush, formerly residents at the Bristol Royal Infirmary.

Dr. Verco then read his paper on a certain method of treating rupture of the female perineum, which will be found on page 164.

PATHOLOGICAL SPECIMENS.

Dr. Verco exhibited a macerated skull of a monster destitute of a cerebral cavity, and gave the following description:—

The base of the skull is fairly well developed, but the basi occipital is united with the basal part of the sphenoid at an angle—about a right angle, looking at it from the cranial cavity. The foramen magnum is of normal size, but, unlike that of a normal adult, its transverse diameter is greater than the antero-posterior. The occipital bone behind the foramen magnum is well developed as high as the occipital protuberance, *i.e.*, as high as the muscles are attached; but, instead of extending nearly horizontally backwards, it rises upwards and forwards at about an angle of 60°, parallel really with the basi occipital, so that it simply covers over the ascending spinal marrow without expanding into a cranial cavity. Above the occipital protuberance the bone ceases with a smooth curved margin, the supra-occipital being represented by a small wing-like continuation, about a quarter of an inch broad and of the same length. At the sides it articulates with the mastoid portions of the temporal. The temporal bone is well developed. The petrous bone, the mastoid, and the tympanic are all present and of natural size; the squamous portion has the zygomatic process fully developed, and the part where it is applied to the petrous bone; but the expanded part that should enter into the formation of a cranial cavity is absent. It articulates in front, as it should, with the large wing of the sphenoid. The parietals are wholly wanting. The sphenoid deviates very little from the normal. There is a well developed basal portion, and great wing, articulating with the basi occipital and petrous, and squamous portions of the temporal behind. Above there is no parietal, so the frontal bone is united along the whole of its articulating

edge. In front its articulations are normal. The frontal is wonderfully altered. It may be said to have been reduced to a nasal process, continued into an orbital margin and then extended into an articulating process, passing outward and backward. Instead of rising nearly vertically upward, it lies nearly horizontal, with an inclination downwards, so as to be almost applied to the base of the sphenoid and the middle of the petrous portion of the temporal. The prolongation backwards passes very curiously under the little wing of the occipital above mentioned and articulates with it, in front of that with the outer part of the petrous portion of the temporal, then with the undeveloped squamous part, and then with the wing of the sphenoid. It has no orbital plate at all, except a narrow vertical ridge separating the orbit from the nose. In consequence of the want of development of the cranial vault, especially of the frontal bone, the margins of the orbit, instead of being vertical, lie at an angle of about 30 deg. with the horizontal, and look almost directly upwards. The orbits are not shut off from the cranial cavity, but open directly into the middle or temporosphenoidal fossa. There is absolutely no cerebral cavity. There is an oval opening in the cranium one inch wide and three-quarters of an inch from before back, bounded in front by the frontal and behind by the occipital curving towards one another. The posterior two-thirds of this hole reveal the continuation upwards of the spinal cavity; in the anterior third are seen the petrous part of the temporal and the basal part of the sphenoid, which are almost on a level with the depressed frontal, leaving just a fissure for the nervous matter to pass into the middle fossa. This fossa is about large enough to hold a small shelled almond and opens widely into the orbit; the nasal processes of the frontal roof in a canal of about the diameter of a crow-quill going on to the nose.

In fine, we may say that provision is only made in this skull for the attachment of muscles of the face and neck, for the medulla oblongata, and for the protection of the nervous matter connected with the special senses and the cerebral nerves; none whatever for a cerebrum or cerebellum. Or, looking at it from a developmental point of view, all those parts of the skull that are related to the brain, which are originally laid down in cartilage and ossify from cartilage, are present, but that the parts which develop from membrane are almost wholly, if not entirely, wanting.

Mr. Lloyd exhibited a characteristic specimen of ulceration of the small and large intestine from a case of typhoid fever.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, APRIL 15, 1885.

EDITORIALS.

CORONERS' JURIES.

ONE of the most remarkable cases in Medical Jurisprudence which has ever occurred in Australasia is now being investigated in Melbourne. Some months ago a person named Slack, of eccentric habits and conduct, was found dead in his bed, with a large wound in his throat, and a razor grasped in his hand. An inquest was held, and a verdict of suicide, whilst in a state of unsound mind, returned by the Coroner's jury. No post-mortem examination was made, and this verdict was accepted by the authorities and the public as satisfactory. Some four months, however, after, a prisoner in one of the Victorian gaols, named Barnes, made a confession, that on the night on which the death occurred, he had burglariously entered the deceased's house for the purpose of robbing him of the money and valuables he was supposed to keep on the premises, and that, being disturbed by Mr. Slack awaking, he throttled him to avoid detection, afterwards cutting his throat and placing the razor in his hand, to convey the idea that he had committed self-destruction. On this confession being made, inquiries were set on foot which almost, if not quite, substantiated its truth; articles stolen, known to have been in the possession of the deceased shortly before his death, having been pawned by the self-confessed murderer. Whilst, on the body being exhumed, a post-mortem examination made by qualified experts, obviously revealed the fact that the deceased had been throttled, and that the wound was not self-inflicted. It does not say much for the wisdom of the coroner, whom we regret to say is a medical

man, that a very plain case of murder was, through petty economy in saving three guineas for a post-mortem examination, accepted, on the authority of the police, as an obvious case of suicide, and this it would always have been thought but for the voluntary confession of the murderer.

The whole affair shows how little is gained and how much is lost by the present system of Coroners' Inquests with juries. In large towns the first twelve men near are caught by the police and sworn in as a jury. Some of these frequently possess but little sense, character, or judgment, whilst a majority of the rest are busy men, who, being kept away from their business by what they consider the trivialities of a Coroner's Court, are often only too happy to agree to any verdict which will release them quickly and are not inclined to listen to any more evidence than they are absolutely obliged to, the verdicts arrived at being in frequent instances monuments of absurd folly. One, for instance, on record in New South Wales, on the body of a child which was found on a road, with a fracture of the skull, exposing the brain, is, "We find that the cause of death was sunstroke, in consequence of the rays of the sun having entered the brain through the hole in the head." In country towns persons are so well known that the friendly feelings, or the reverse, of the jurymen towards the persons interested are involved, and whilst one man is without hesitation condemned by them, nothing in the world will induce them to give an adverse verdict to another. One reason for this is that they know that their adverse verdict only means committal for trial and the consequent annoyance and expense to the prisoner, and is in no way final, they therefore do not feel the same responsibility which an ordinary jury does. In the bush, away from towns, nothing is more cumbersome and inconvenient than the jury system in inquests. A body, perhaps, is found at a solitary hut a long distance away from other inhabitants, and a jury has to be hunted up and men brought from miles around to attend an inquest, which could be much better conducted by a magistrate, a medical practitioner, and the police alone. We think it would be immensely to the public benefit to abolish Coroners' Juries altogether and to appoint particular magistrates in each district to make inquiry into the circumstances surrounding all suspicious deaths. The evidence taken at this inquiry should be submitted, with the recommendation of the magistrate sitting, to the Crown Law Officers, who, if they found the evidence justified it, would direct the police to take proceedings against the persons whom the depositions implicated. This would more effectually fulfil all that Coro-

ners' Juries do at present, with less expense and trouble to the authorities or individuals, and it is what is done at the present time in those districts in New South Wales where the Government have wisely neglected to appoint coroners.

THE EXCLUSION FROM THE COURT OF MEDICAL WITNESSES IN MELBOURNE.

DR. NEILD, the lecturer of Forensic Medicine in the University of Melbourne, has recently written a letter to the *Argus*. In it he gives particulars of a trial, in which, when being tried at the Criminal Court, Melbourne, the medical witnesses were ordered, with the others, to leave the Court during the hearing of the case. We think Dr. Neild has done a public service by the attention which he has called to this incident, for medical men are subpoenaed as experts to testify to certain scientific facts, and to judge and express their opinion of the evidence given by the ordinary witnesses, so far as it relates to the medical aspect of the case. If they are not allowed to remain in Court, how is this to be done, for the evidence as given by a witness is frequently very different from what is professedly the same, when put by the barrister for the defence, whose business perhaps it is to distort it in such a manner as to tell best in the interests of his client. It is to be hoped, for the public well-being, that this recent action will not be allowed to be a precedent in future cases; but it is the public generally, and not the profession, who will suffer if it is continued.

THE CHRISTCHURCH, N.Z., HEALTH OFFICER'S REPORT FOR 1884.

WE have received a copy of the report of Dr. Nedwill, Medical Officer to the Board of Health for the district of Christchurch, N.Z., and it shows in a most marked manner the decrease of the death rate in proportion to the advance made in the sanitary improvements. The number of deaths has steadily decreased year by year, with the exception of 1883, when there was a sudden rise, the cause of which the report does not give. In contrast to 1875, when it is to be presumed the sanitary arrangements of this district were in a very primitive state, the lessening of the mortality is most gratifying, for in 1884 it was but a little more than a third of what it was in 1875.

SALVATION ARMY HOME FOR FALLEN WOMEN IN MELBOURNE.

ON March 31st the representatives of the Salvation Army in Melbourne waited on the Hon. Jas. Service, the Victorian Premier, to request the Government of that colony to grant £1000 to them in aid of the erection of a Home for Rescued Women, where they could be treated for contagious disease. Mr. Service said the idea had his hearty sympathy, and he would submit the request to Parliament, when no doubt the sum would be voted; but, if not, he would willingly make one of ten to subscribe the amount.

We must congratulate the Salvation Army on the practical good sense shown in their proposal, and trust they will succeed in their project, when they will do more good than the mere relief which they will afford to the inmates, by the useful example they will give to the community generally of the advantage arising from the establishment of special hospitals for the treatment of these diseases, if only on the ground of political economy. In these colonies any home for the reformation of prostitutes which does not provide for the treatment of contagious disease, must of necessity be a farce and a failure, for no woman in Australia who is in good health need remain a prostitute twenty-four hours, should she have a genuine desire to reform and change her mode of gaining a livelihood. A woman of this class, who has become disgusted with her way of life, if her repentance is genuine, has but to exchange her gaudy finery for decent apparel, befitting a domestic servant, to be able at once to obtain a situation as one in a respectable family, where, if she is in earnest in her endeavour to lead a new life, and does her best to perform the duties which she has undertaken, she will be looked upon as a treasure and no impertinent inquiries will be made as to her former life. A healthy woman, who requires the bolts and bars of a "Home" as aids to repentance, is not a genuine penitent, and will without doubt relapse as soon as the temporary impulse has passed away, whilst the genuine Magdalen, who would not require these aids to reformation, would be exposed to innumerable and unnecessary annoyances at the hands of many of her sex whom circumstances, temperament, or the disinclination or fastidiousness of tempters generally, have enabled them to retain their much belauded virtue, and thus place them on a pedestal from which they look down with pitying superiority on their more human but less frigid sisters.

THE SYDNEY ABORTION CASES.

At the recent Circuit Court, held in Sydney, a man named Thomas Meredith Sheridan was convicted of using instruments and administering drugs, with intent to procure abortion, in two cases, and sentenced to fifteen years penal servitude. In one of these, a man named William Bell, the husband of the woman on whom abortion was procured, was sentenced to eight years as an accessory, and in the other, Edward Dominic Bac, the paramour of the other woman, was sentenced to five years on the same charge. Though Sheridan was only tried on two charges, he had been committed on four, which came to light, and without doubt he has been guilty in numerous others which have not come out. In each of the four cases the unfortunate woman died, and post-mortem examinations disclosed the fact that, in his design to procure abortion, Sheridan had in each case perforated the uterus in the cervix, in some of them more than once, with the instrument which he used to effect his purpose.

Under the old law, the prisoner would have been liable to be, and doubtless would have been tried and convicted of murder, as the death occurred in consequence of his action in the carrying out of a felonious purpose, but under the new Criminal Law Consolidation Act of New South Wales this is not practicable. The prisoner, Sheridan, was one of the unqualified practitioners so numerous in New South Wales, where there is no Act to prevent any man practising as a medical practitioner if he chooses, and the special lesson which this series of tragedies teaches is, we take it, the necessity it shows for the passage of an Act for the regulation of medical and surgical practice in that colony. As it is, any man, under the guise of being a medical practitioner, may commit an unlimited number of similar crimes, and except he is found out, and evidence is forthcoming, strong enough to convict him, can do so with impunity. These men have no standing, professional or social, and risk little more than their reputation—an inappreciable thing—by their conduct. A very different

position would be that of a properly educated and registered practitioner, who was guilty of similar conduct. He would not only run the chance of conviction on sufficiently good evidence as does the other, but, in addition, would be liable to be removed from the list of medical practitioners and from the list of the colleges from whom he received his diplomas. Thus, if medical practitioners who were registered, were only allowed to practice, that "rara avis," a black sheep amongst them would, equally with the rest of the disreputable crew be prevented from doing it in the future, and this might be done on evidence exact enough for the purpose, and morally sure, yet technically not good enough for a Criminal Court, where the prisoner is entitled to the benefit of every doubt. We would ask who suffered by Sheridan's criminal practices, and who suffers by the state of things which still renders such things easy—the profession or the public? We think no one will hesitate a moment in saying the latter, and the latter only.

LEADING ARTICLE.

ON THERMIC DIARRHŒA.

By JOHN SERVICE L.R.C.S. AND L.R.C.P.,
ED., ETC.; LATE MEDICAL OFFICER IN CHARGE
OF THE HOSPITAL SHIP "FARAWAY," NORTH
HEAD, SYDNEY HARBOUR.

A RECENT slight outbreak of this complaint among the convalescents from small-pox on the Quarantine Station, has recalled to my mind the fact that, in the north of England, during the summer and autumn months, the largest proportion of a medical man's work often consists in attendance upon cases of the kind. Having observed that the disease is also common here, and identical in character with, and amenable to the same treatment as that at home, I will, with your permission, shortly summarize a ten years' experience of it in England.

Known under the various names of Summer Diarrhœa, Autumnal Diarrhœa, English Cholera,

British Cholera, Choleraic Diarrhoea, and, best of all, *Thermic Diarrhoea*, this disease is endemic in many parts of Britain during the months of June, July, August, and September, dying gradually away as the bracing cold of winter sets in. In certain districts, particularly, as I have observed, on the north-east coast of England (Northumberland and Durham), it is at times so widespread and sudden in its onslaught as to resemble an epidemic, and the severity of its symptoms are such as to have earned for it some of the names it bears, and to account for the "sporadic cases of Asiatic Cholera" with which the public mind is needlessly startled at times. As I shall endeavour to show, however, its occasional occurrence at other times than in the "cholera season," and its endemic prevalence at all seasons where the conditions of life are such as to resemble the thermometric variations of the summer and autumn months of England, go to prove that though there may be, and probably often is, a septic element in the aetiology, its main origin undoubtedly is a *chill* supervening on exhaustion from any cause, nervous depression, convalescence from disease, or in the badly fed and clothed. I found nothing so common in the history of the complaint as an attack beginning immediately after the removal of body flannels, and, on the other hand, its speedy disappearance on their timely resumption. A large proportion of the cases occurred in the early hours of the morning when vitality is at the ebb, and when the temperature of the air is liable to sudden falls. During a hot night the bed-clothes are kicked off, a fall in the temperature comes, and the mischief is done.

Six convalescents and two attendants in the hospital enclosure here were attacked about 2 a.m. on Sunday, 18th January. The 17th and previous days had been hot and sultry, minimum temperature 76° Fah. in the shade; but during the nights of the 17th and 18th, there was a sudden drop of 6°, the wind veering from N. to S. Sixty eight degrees Fah. in England would be considered a *warm* temperature, but here it is different, it is comparatively cold. It is the relative, not the absolute drop that is dangerous. Now among the pitmen of Northumberland and Durham, diarrhoea is endemic at all times, and the nature of their work is a sufficient explanation. It is laborious and miserably paid. They are underfed and poorly clad to begin with. They come "oot bye" from "the feyce," where the temperature may be 70° to 90° or more; and in addition to meeting the incoming draughts of cold air, they have often to stand for an hour or more at the pit bottom waiting their turn "to ride." Attacks of diarrhoea among them are frequent when the

disease is entirely absent from the women and children of the household above. It is fair to add, however, that these attacks are particularly common among those who are employed in "the waste," that is, in the air currents which are travelling to the ventilating furnace, and which currents have gone the whole round of the pit, and contain therefore a considerable proportion of animal and gaseous impurities. Whether this vitiated air, which certainly has a bad and peculiar odour, contains any specific organism which could be credited with causing the disease in question, or other diseases, is, I think, a point which is worthy the attention of micro-biologists.

In the pit villages above, as I have said, the disease is, during the summer and autumn months, exceedingly prevalent; but there also, it occurs at other times—chiefly, however, in the ill-fed and scantily clothed. The rigour of an English winter is something to be remembered, and how some of these poor wretches live through it in their linen tatters was always a mystery to me. The sensible and provident portion of the community of course clothe in flannel; but, while some reject the advice to do so and are the victims of their own ignorance and obstinacy, there are others who really have not the wherewithal to clothe properly and who suffer in consequence. Altogether the large mortality from seasonal diseases is small when we consider the conditions.

I do not propose here to enter into any enumeration of the well known symptoms of thermic diarrhoea, but upon pathology I have one or two passing notes to make. A chill or rapid and sudden loss of body heat having taken place, there is a rallying of the blood round central organs. A capillary stasis becomes established along the alimentary mucous tract and copious exosmotic action begins. The cause of the cramps is not always clear, unless, indeed, we suppose that the turgescence condition of the intestinal villi be in itself their reflex origin. Recent food, and particularly fresh herrings, new potatoes, fruit, etc., are often, and I believe erroneously supposed to be the offending material. The disease frequently exists where these are not, and the state of the tongue is often such as to indicate no particularly irritated or even atonic condition of the digestive mucous tract. In the way of *treatment*, I believe the main indications to be these:—

1st. Prophylactic.—Flannel, or other non-conducting cloth, should be worn next to the skin in all countries, during all seasons, and by everyone. Such clothing need not be burdensome, the *material*, not its thickness or weight, is the desideratum.

2nd. Curative.—Fill the surface vessels with blood. If, immediately the attack begins, a large

poultice of hot linseed and mustard made in the following way, be applied over the stomach and bowels, very often no other treatment beyond rest in bed for a few hours will be required. Two or three tablespoonfuls of linseed meal should be stirred up in a basin with hot water (not quite boiling, or the myrosin, sinapsin, etc., of the mustard will be destroyed.) Spread the linseed out on a cloth and cover it thickly over with mustard, made with cold water as for the table, and not too thin; cover all with a piece of thin muslin and apply for twenty minutes or half an hour. In the case of children, the mustard should be *mixed* with the linseed, proportionately to age—for infants one fourth mustard, up to six or seven a third, up to twelve or thirteen half and half.

Stimulants during this stage should be avoided. Diet should consist only of milk and soda water iced. Hot fluids of any kind must be withheld. They increase the exosmosis and peristalsis, already morbidly excited. If pain is not relieved by the sinapism, opium in some form must be given, and it is astonishing under such circumstances what doses are often required. I have frequently seen a man suffering from the cramp of diarrhoea swallow half an ounce of laudanum with no other effect than a temporary relief of his pain. Hypodermic injections of morphia are most effectual; but, usually, the mustard will be sufficient. Should any looseness now persist, the following mixture, with or without the addition of $\text{m}\nu$. to $\text{m}\chi$. doses of tr. opii . as may be required, will almost certainly check it:—

\mathcal{R} —Cretae Praeparatae gr. clix.
Spt. Chloroformi Co. ziiss .
Decocti Haematoxyli ad. zviii .
Sig. zi quarta quaque hora, ex aqua,
vel p. r. u.

In the Grampian Ranges of Victoria, the root of a flowering plant known as the "Native Geranium," enjoys a great reputation for the cure of this form of diarrhoea, which is there very prevalent. I have tried it in several cases with some success. It has an agreeable astringent taste, and contains, I find, a large proportion of tannin. It is not in any way superior or even equal to catechu and other better known vegetable astringents. Vomiting and thirst will be best allayed by ice, and brandy or champagne must be freely given if exhaustion is imminent.

But the essential point in the treatment of this condition is to see that the abdominal surface is well reddened.

During convalescence, the vegetable tonics or quinine will be found beneficial; and to counteract the tendency to constipation, which almost always exists, the patient may use brown bread, oatmeal cakes, etc., and take a mixture containing Nux Vomica with a mineral acid.

THE MONTH.

NEW SOUTH WALES.

At a special meeting of the Senate of the Sydney University, held on March 21, a report from the Faculty of Medicine was read, in which it was stated that the faculty declined to draw up rules for the general recognition of all hospitals on the ground that "no good result would accrue from their drawing up rules which the Senate might not approve of, and which the Hospital authorities would certainly decline to be bound by;" and also that it adhered to its recommendation that recognition should be withdrawn from St. Vincent's Hospital for the reasons stated in their former resolution, until the authorities of the Hospital had submitted for the approval of the Senate their rules for the appointment of the medical staff and their regulations with reference to the teaching given. After considerable discussion, it was resolved, on the motion of the Dean of the Faculty, seconded by Mr. Rolleston—"That the report be withdrawn, in order that it may be submitted to the faculty for further consideration." A letter from Professor Liversidge, urging the necessity of erecting suitable buildings for the Chemical department without delay, was considered. The Chancellor was requested to communicate with the Government upon the subject at the earliest opportunity. The members then visited the grounds for the purpose of fixing a site for the Macleay Museum and for the new Medical School, and for that of the Chemical department. It was finally decided—That the Macleay Museum should be erected on a site to the north-west of the great hall, towards the Parramatta-road; that the new buildings for the Chemical department should be erected on a site at the southern end of the main University buildings, at a distance of 80 feet from them, and in line with the general front; and that the Medical School should be erected on a site at a distance of 80 feet from the Chemical department, and in line with the front of the great hall.

THE University of London has consented to accept the University of Sydney as an institution from which that University will receive certificates of attendance of students desirous of graduating therein.

At a meeting of the Board of Directors of the Sydney Hospital, held on April 7, the following resolution was adopted: "That the services of Drs. Woodward and Musket be accepted temporarily for the proposed gynaecological department for the outdoor treatment of diseases of women."

THE usual clean bill of health was issued by the health authorities to all outgoing vessels from March 17.

DIPHTHERIA is prevalent at Nyngan.

A good deal of sickness, principally typhoid fever, is prevalent in the Penrith district.

T. M. SHERIDAN, a chemist, was found guilty, at the Central Criminal Court, Sydney, on March 19, of having caused the death of Mrs. Bell, and also with having, on the 10th November last, unlawfully used on her a certain instrument with intent to procure abortion. He was also convicted, on March 25, of having used an instrument with intent to procure a miscarriage, on Sarah Hales, of Petersham. This case was tried some days previously, when the jury failed to agree as to their verdict. The sentence was 15 years penal servitude.

DR. W. F. P. BASSETT, house surgeon at the Bathurst Hospital, has resigned.

MR. JOSEPH WALTER DAVIES, M.R.C.S., Eng., et L.S.A., Lond., 1856, died at Quirindi, on March 26.

DR. SMITH HOZIER, Government medical officer of Gundagai, met with a serious accident on March 12, through his horse colliding with a tree and throwing the doctor to the ground with great violence. A medical man was sent for to Tumut, who, on his arrival, discovered that Dr. Hozier had an arm and two ribs broken, one shoulder dislocated, and one thigh severely injured, but hopes are entertained of his ultimate recovery.

DR. L. J. HALKET, formerly house surgeon at the Sydney Hospital, has commenced practice at Quirindi.

DR. INGLIS, while riding on horseback in Hunter-street, Newcastle, on March 30, met with a painful accident. The animal he was riding collided with another horse in a dray, and on examination it was found that his ankle was dislocated.

DR. JOS. LAUTERER, a recent arrival from Baden (Germany), has settled at Hill End, an important mining township, 205 miles W. of Sydney.

DR. STANISLAUS MAGUIRE, of Molong, has been appointed Captain in the 2nd Regiment N. S. Wales Volunteer Infantry.

DR. H. M. MASSEY, late of Robe and Moonta (S.A.), has commenced practice in the Newcastle district, in conjunction with his cousin, Dr. G. W. Baker, of Hamilton.

DR. WALTER LE CROIX O'REILLY, M.D., New York Medical College, 1851, late of Hill End, died at the residence of his son, Dr. W. W. J. O'Reilly, 157 Liverpool-street, Sydney, on March 11, in his 61st year.

DR. W. F. QUAIFFE, a native of the colony, has returned to Sydney from the Glasgow University, and commenced practice at Woollahra, an important suburb of Sydney, in conjunction with his brother, Dr. F. H. Quaife.

DR. JOHN SERVICE, late resident medical officer at the Quarantine Station, Port Jackson, has commenced practice at Newtown-road, corner of Bligh-street, Newtown, a suburb adjoining Sydney.

DR. A. R. STACPOOLE, late resident medical officer at the Sydney Hospital, has succeeded to the practice of Dr. C. H. Scott, at Cobar, the centre of a copper mining district, 490 miles W. of Sydney.

DR. E. S. TRESIDDER, late of Creswick (Vic.), has purchased the practice of Dr. H. L. Cortis, of Ooonamble. Dr. Cortis has removed to Bathurst, where he has taken temporary charge of the local hospital.

MR. W. SHEPPERSON, travelling agent for the well-known firm of Messrs. Burroughs, Wellcome and Co., manufacturing chemists, London, who for the last two years visited India, China, Phillipine Islands, Japan, and Java, arrived in Sydney early this month. Mr. Shepperson, we understand, intends making a thorough tour through Australia, Tasmania, and New Zealand, with a view to introduce some of Messrs. Burroughs, Wellcome and Co.'s new preparations, which have already received attention and been favourably reported upon by many leading medical men at home.

NEW ZEALAND.

THE Colonial Secretary is understood to be now engaged in the preparation of a Bill for the management of hospitals and other charitable institutions.

We understand that the Hon. Visiting Medical Staff of the Auckland District Hospital have forwarded a

joint letter to the Hospital Committee, expressing regret at learning that the Committee have requested Dr. Bond to resign his position as House Surgeon. They state that they are now perfectly satisfied with the manner in which he is performing his duties.

THE local Board of Health at Christchurch has decided to urge on the Government the necessity of an infectious diseases hospital.

THE Christchurch Hospital Board held a special meeting on January 30 to consider the evidence taken in the recent inquiry as to the operation on the patient, William Strickland, who has since died. The Board found that the operation was performed without consultation with the staff, and the weight of medical evidence is in favour of the operation being considered a major one; but the circumstances surrounding the case offer some justification for Dr. Stewart omitting to consult his colleagues. The Board desires to place on record that the result of the inquiry has in no respect diminished its confidence in Dr. Stewart as honorary visiting surgeon to the Hospital. It was resolved—"That the Board take into consideration at next meeting the evident laxity in holding consultations, and other matters affecting patients, which have been brought out during the inquiry."

THE Christchurch Hospital Board held a long meeting on February 17, when it was decided by a majority of one not to ask for a Royal Commission to enquire into the management of the institution, but, as all the papers connected with the recent troubles had been sent to Government, the matter should be left in their hands.

DR. T. C. MOORE, late in the P. and O. Steam Navigation Company's service, has settled at Helensville, on the southern shore of Kaipara Harbour, 30 miles N. of Auckland.

DR. ARTHUR WATSON, late of Manchester (Eng.), has commenced practice at Clinton, in an agricultural and grazing district, 79 miles S.W. of Dunedin.

QUEENSLAND.

DENGUE FEVER, which first appeared in the years 1827 and 1828, in the West Indies, and in the Southern States of North America, is now prevalent in Rockhampton to an alarming extent. A large number of cases have already been recorded, amongst them Drs. Brown, Stuart, and Thurston, who by the middle of March were very ill and quite unable to move out of bed. Dr. Thon also had a slight attack of the fever, but we are glad to learn has now recovered and resumed his practice.

A SURGEON is required for the Hodgkinson District Hospital at Thornborough, a declining mining township in Northern Queensland. The salary is £300 per annum, private practice allowed, which, however, is almost nil. Applications must be sent to the secretary, Mr. A. A. Mayou.

DR. J. A. H. BUDGETT, a new arrival, has settled at Rockhampton.

DR. S. CANDIOTTIS, of Clermont, has removed to Rockhampton.

DR. F. O. HODSON, late Resident Assistant Surgeon at the Hospital for Pacific Islanders, Mackay, and formerly Medical Officer to the Hillston Hospital (N.S.W.), has joined the Queensland Immigration service.

DR. LEONARD REDMOND, a new arrival, has commenced practice at Charters Towers.

SOUTH AUSTRALIA.

FROM the Annual Report of the Adelaide Hospital, we learn that during the past year 2129 patients were admitted, and that of these 159 died; the average daily number of patients in the hospital was 172; the average number of days which patients discharged have been in the Hospital is stated to have been 28. The annual cost of each in-patient was £56 14s. 2d., and the total annual expenditure £10,693 3s. 9d. The fees received from paying patients amounted to £796 10s. 4d. The number of attendances of out-patients treated was 8218. These statistics, as compared with those of 1883, show the following increases, viz., 10 in the number of patients admitted, 7 in the daily average of hospital inmates, 557 in the number of attendances of out-patients, £144 7s. 6d. in the total expenditure, and £164 5s. 5d. in the amount of fees received for the maintenance of patients. There being a decrease of 15 in the number of deaths and £2 in the annual cost of each in-patient. The number of cases of enteric fever admitted during the year was 223, with 18 deaths; 20 patients died from phthisis, and 18 from heart disease. Of the 297 operations performed, 168 proved successful, 22 were unsuccessful, 90 patients were relieved, and 17 died.

A HOUSE SURGEON is required for the Adelaide Children's Hospital. The salary is £200, with board and residence. Applications, with testimonials, must be sent to the secretary, Mr. R. C. Norman, before April 30.

DR. E. B. CASHEL, late of Armadale, near Melbourne, has commenced practice at Balaklava, in an agricultural and pastoral district, 67 miles N. of Adelaide.

AMONG the passengers by the P. and O. steamer Pekin was Dr. Archibald Watson, the new Professor of Anatomy selected to the chair founded by Sir Thomas Elder in the Adelaide University.

TASMANIA.

THE HON. WILLIAM LODEWYK CROWTHER, M. 1841, F. 1874, R.C.S., Eng., one of the oldest practitioners of Hobart, died at his residence on April 12, at the age of 68 years. The deceased gentleman was a member of the Legislative Council of Tasmania, a member of the Tasmanian Court of Medical Examiners, and Surgeon-Major in the South Tasmanian Volunteer Artillery, also twice a Minister without a portfolio.

VICTORIA.

THE cancer ward of the Austin Hospital for incurables, near Melbourne, was opened by Lady Loch, on March 9.

THE following candidates have succeeded in passing the examination for the M.D. degree at the Melbourne University:—James William Florance, M.B.; William Moore, M.B.; Frederick James Owen, M.B.

THE Hon. Dr. J. G. Beaney, M.L.C., honorary surgeon to the Melbourne Hospital, intends to visit Europe shortly. He will be absent for six months.

THE Hon. Dr. Beaney has offered the Committee of Management of the Melbourne Hospital a piece of land, to be vested in trustees, for the purposes of the projected Consumptives' Hospital.

DR. W. H. BROWN, late of New Basford, Nottingham (Eng.), has commenced practice at Stawell.

MR. RICHARD BUNGE, M.R.C.S.E., 1842, a resident of Ballarat for 25 years, died on March 29, after an

illness extending over ten months. He occupied the position of Health Officer for that city and the suburb of Sebastopol, also Medical Officer of the Gaol and Reformatory for many years.

DR. J. B. CROSS, of Horsham, is going home for twelve months. Dr. G. B. Faskally, formerly surgeon to the Sidmouth Dispensary, will carry on his practice during his absence.

DR. JAS. DAVISON, a new arrival, has commenced practice at Tatura, a post-town, 110 miles N.E. of Melbourne.

DR. F. W. A. GODFREY has settled at St. Kilda, a fashionable suburb of Melbourne.

DR. C. E. GRAY, formerly of the Royal Navy, and lately Government Medical Officer and Surgeon to the Hospital at Inverell (N.S.W.), has commenced practice in Simpson-street, East Melbourne.

DR. M. HERDEGEN has resigned his appointment as Public Vaccinator for Nhill.

DR. J. W. D. HOOPER, late House Surgeon at Gray's Hospital, Elgin (Scotland), has settled at Harrow, in a pastoral district, 274 miles W. of Melbourne.

DR. R. F. HUDSON has returned to Ballarat from his trip to England.

MR. HUGH MACINTOSH, L.R.C.S., Irel., 1875, died at his residence, Alma-street, St. Arnaud, at the age of 38 years.

DR. F. H. MEYER, the Resident Surgeon of the Lying-in-Hospital, Melbourne, who is about to resign his position, after occupying it for four years, was, on March 24, presented by the nurses with a handsome bag of instruments and an address expressing their gratitude for his kindness, and the deep regret they felt at the prospect of his retirement. Dr. Meyer suitably responded.

MR. J. J. SHILLINGLAW, late secretary to the Victorian Central Board of Health, has been reinstated in the public service, after the departmental board which investigated his case finding that the charges made against him by Mr. Akhurst, chairman of the board, to be frivolous.

DR. J. W. SMITH has resigned his appointment as Public Vaccinator for Ballan.

DR. W. S. SMYTHE, of Port Melbourne, has resigned his appointment as Surgeon in the Victorian Naval Reserve.

DR. DAVID ELLIOT WILKIE, M.D., Edin., 1836, L.R.C.S., Edin., 1838, M.D. (*a. s. g.*), Melb., 1866, an old colonist of Victoria, who left Melbourne in November twelvemonths on a visit to Europe, died at Paris on April 2, aged 70 years. He came to South Australia in 1838, and the next year he came to Melbourne, where he entered on his medical practice, which he continued until 1881. He was a member of the Legislative Council from 1856 to 1868, and in 1861 he represented the Heales Government in that House. He was one of the founders of the Mechanics' Institute and of the Philosophical and Royal Societies. He originated the movement which led to the Burke and Wills expedition, and he was connected with many other important movements. He has left a family of four sons and five daughters.

BIRTH.

NORRIE.—March 16, at 171, Liverpool-street, Hyde Park, the wife of A. Norrie, M.D., of a son.

MEDICAL APPOINTMENTS.

- Aitchison, Alexander Smith, M.B. et Ch.B., Melb., appointed Resident Medical Officer at the Sick Children's Hospital, Carlton, Melbourne.
- Biroh, Lewis John, M.B., Melb., to be Health Officer for shire of Alberton, Vic.
- Brisbane, Matthew, L.R.C.S., Edin., to be Health Officer for shire of Kara Kara, Vic.
- Canny, Denis Joseph, L.R.C.P., Edin., M.R.C.S.E., to be Government Medical Officer and Public Vaccinator for the district of Port Stephens, N.S.W.
- Cashe, Edward Baldwin, L.R.C.S., Irel., L.K.Q.C.P., Irel., to be Public Vaccinator at Balaklava, S.A.
- Dickinson, William Miller, M.B., L.R.C.S., Edin., to be Acting Public Vaccinator for Hamilton, Vic., during the absence on leave of Dr. W. E. L. Hearn.
- Jack, Robert Nelson, L.R.C.P. et R.C.S., Edin., to be Health Officer for Stawell, Vic.
- Lauterer, Joseph, M.D., elected Medical Officer to Hill End Hospital, N.S.W.
- Lethbridge, Charles Frederick, M.R.C.S.E., to be Public Vaccinator at Alexandra, Vic.
- Mackdonald, Hugh, M.D. et Ch.M., Glas., to be Public Vaccinator, Government Health Officer, and Surgeon to the Gaol, Lyttelton, N.Z.
- Marr, Joseph Bell, L.F.P.S., Glas., L.R.C.P., Edin., to be Public Vaccinator for Ballan, Vic.
- Miller, William Francis, M.B. et Ch.B., Melb., M.R.C.S.E., L.R.C.P. et R.C.S., Edin., to be Health Officer for Carisbrook, Vic.
- Moore, Thomas Charles, M.D., Dubl., to be Public Vaccinator for the Helensville district, N.Z.
- Phillip, Alexander, L.K.Q.C.P. et R.C.S., Irel., to be Public Vaccinator for city of Sydney and suburbs.
- Ryan, Timothy Bernard, M.B. et Ch.B., Melb., to be Government Analyst for shire of Kyneton, Vic.
- Steeppole, Adam Richard, L.R.C.P. et R.C.S., Edin., to be Government Medical Officer and Vaccinator for the district of Cobarr, N.S.W.
- Stewart, Douglas Edward, M.B. et Ch.M., Edin., to be Health Officer for shire of Coburg, Vic.
- Swanson, Charles, L.R.C.P. et R.C.S., Edin., to be Government Medical Officer for the district of Mudgee, N.S.W.
- Tibbitts, Walter Hugh, M.R.C.S.E., to be Government Medical Officer and Vaccinator for the districts of Manly and Pitt Water, N.S.W.
- Tuthill, John, L.R.C.S., Irel., L.K.Q.C.P., Irel., to be Government Analyst for shire of Euroa, Vic.
- Twoeddale, John Dunbar, M.R.C.S.E., to be a Member of the Victorian Central Board of Health.
- Welchman, John Arthur Cromwell, M.B. et Ch.B., Melb., to be Medical Officer to attend to the Destitute Poor and Aborigines for the district of Clarendon, S.A.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

- Quaife, William Francis, M.B. et Ch.M., Glasg., 1883.
- McLeod, James, M.B., Edin., 1884; M.S., Glasg., 1884.
- Lauterer, Joseph, M.D., Freiburg, 1872; Staats-Examen Certificate, Carlsruhe, 1872.
- Pierce, William, M.B., 1863, M.D., 1865, Dub.; L.R.C.S., Irel., 1864.
- Kendall, Peter Slade, L.R.C.P. et R.C.S., Edin., 1879.
- Grant, David, M.B. et Ch.M., Edin., 1876.
- Tomlins, William Henry, L.S.A., Lond., 1884; M.R.C.S.E., 1884.

NEW ZEALAND.

- Allen, James Henry, L.R.C.S., Irel., 1872; M.B., 1872, M.D., 1876, Trin. Coll., Dublin.
- Davy, Thomas George, B.A., Oxford, M.R.C.S.E. et L.S.A., Lond., 1883.
- Watson, Arthur, M.B., M. Ch., et L.Mid., 1874; M.D., 1879, Edin.
- Cameron, Malcolm L., M.B., Trin. Univ. Can., 1881; L.R.C.P. et R.O.S., Edin., 1881.
- Lawry, Thomas Spencer, M.B. et Ch.M., Edin.; M.R.C.S.E., 1883.
- Moore, Thomas Charles, M.B. et Ch.B., 1881; M.D., 1884, Dubl.

QUEENSLAND.

- Budgett, John Alfred Henry, L.S.A., Lond., 1875.
- Faskally, George Bleack, F.R.C.S., Edin., 1876; L.S.A., Lond., 1874.
- Goodall, Joseph, M.R.C.S.E. et L.S.A., Lond., 1866; L.R.C.P., Lond., 1867.

VICTORIA.

- Brown, William Henry, M.R.C.S.E., 1863; L.S.A., Lond., 1868.
- Davidson, James, L.R.C.S., Irel., 1879; L. et L. Mid., K.Q.C.P., Irel., 1880.
- Godfrey, Frank William Albion, M.B. et Ch.M., Edin., 1883.
- Teevan, Alfred, M.R.C.S.E., 1877; L.R.C.P., Edin., 1879; L.S.A., Lond., 1879.
- Hooper, John William Dunbar, L.R.C.S. et R.C.P., Edin., 1883.

CORRESPONDENCE.

MEDICO-LEGAL.

(To the Editor of the A.M.G.)

SIR,—Your readers may be interested in the following case even though the evidence is very incomplete, more especially as the effects of heavy bodies on the human form is still subject for inquiry.

On March 6th last, the subject of remark was driving a loaded waggon—gross weight 6 tons—sitting on the shafts, I believe. On attempting to cross the railway line the wheels ran alongside the rails for some distance. On crossing (with a jerk, I presume, the rails being above the level of the road) the driver was thrown from his seat under the wheels, the loaded waggon then passed over his body. Some blood issued from his mouth, I was told, and I observed some about an hour after, when his heart beat for some minutes, although very feebly. Pupils fully dilated until death, when they contracted, cornea reflex did not return. Heat, ether, injections, and magnetic electricity were used, and irritation over heart, &c. On the left over the ribs and to the sternum in front appeared, for a small space, a parchment-like piece of skin, as if a heavy weight had passed over it. The left side of the chest bore evidence of emphysema. I concluded that the left lung was damaged, that the vehicle passed over his body from left to right (a point verified by an eye-witness), but whether one or two wheels passed over I could not say, and that he died from shock. There was no autopsy. It is remarkable that no bones of the limbs were broken, and that the spine (so far as external examination could detect) was sound; also that the sternum was whole, when a weight of 1½ tons passed over the body at least once. The man was strong, muscular, and 32 years of age, so his ribs were undoubtedly elastic.

JOHN REID, M.B. et Ch.M., Aberd.

Port Germein, South Australia.

REPORTED MORTALITY FOR THE MONTH OF FEBRUARY, 1885.

[illegible]

* The Official Monthly Report on the Vital Statistics of Brisbane and Suburbs does not show the number of deaths from the various diseases.

METEOROLOGICAL OBSERVATIONS FOR FEBRUARY, 1885.

[illegible]

NEW INVENTIONS.

[Reprinted from the LONDON MEDICAL RECORD,
December 15, 1884.]

• PREPARATIONS OF DIGESTIVE
FERMENTS.

THE importance of investigating thoroughly, and in a true scientific spirit, the properties of new drugs and new preparations is apparent to every one. In many cases the investigation can be carried on by physicians engaged in active practice, but in other instances the technical knowledge of the physiologist and pharmacologist is needed for a true interpretation of the facts. This co-operation is especially advantageous when dealing with such active and at the same time indefinite bodies as the vegetable and animal ferments. An extract of malt may be a powerful digestive agent, or it may have been prepared at such a temperature as to destroy the activity of the diastase. A pepsin or pancreatin may be an active medicinal substance, or it may be so largely adulterated with starch as to be practically valueless. For some time past it has been known that great improvements have been made in the mode of preparation of Kepler Extract of Malt, and that Fairchild's Scale Pepsine and Extractum Pancreatis were of such activity that nothing at all equal to them had been previously available for use in medicine. The fact that these substances were prepared by a firm so well known as Messrs. Burroughs, Wellcome, & Co., of Snow Hill Buildings, was in itself presumptive evidence that they were not altogether destitute of activity; but still, that was not scientific evidence, and it was felt that a thorough investigation should be made, and an independent opinion given. Acting on the suggestion of several well-known physicians, the Editor of the LONDON MEDICAL RECORD appointed a Commission, consisting of Dr. Ringer, of University College Hospital, and Dr. Murrell, of the Westminster Hospital, to undertake an experimental inquiry, and report with as little delay as possible. The full text of the report has not as yet been received, but it is understood that the following statements embody the chief points on which a decision has been arrived.

1. The Kepler Diastase Extract of Malt was found to be of excellent quality. It is light in colour—showing that it has been prepared at a low temperature—and has a sweet and agreeable taste. It possesses the power of converting starch into sugar to an extent which is exceptional.

2. The Kepler Extract of Malt and Cod-Liver Oil differs but little in appearance from the simple extract of malt. Although it contains 40 per cent. of cod-liver oil, the taste of the oil is hardly perceptible. On examination under the microscope it is found to be a most perfect emulsion, there being no sign or trace of oil-globules present. On holding the slide, covered with the emulsion, up to the light, it was seen to be perfectly transparent.

3. Fairchild's Extractum Pancreatis was ascertained to be a powerful digestive agent. It is alleged of it that it acts equally well in alkaline and in neutral solutions; but this point the Commission reserved for further investigation. It completely transformed the casein of milk into peptones, so that in a few minutes no curdling was produced even

with nitric acid. Examined under the microscope, it was seen to be entirely free from starch.

4. Fairchild's Scale Pepsine was found to exert a speedy and effective action on fibrin. An investigation of its action on egg-albumen was reserved for a future occasion. An opinion was expressed that the new pepsine was to be regarded as an efficacious and trustworthy preparation.

5. The 'McK. & R.' Capsuled Pills were examined incidentally, and the coat was found to dissolve completely in about thirty-five seconds.

6. The Compressed Tablets of bisulphate of quinine, made without the addition of any adhesive or other substance, were found to be readily soluble in water at the temperature of the body. They were found to be uniform in size, and remarkably accurate in weight. The compressed tablets—of aconitia, atropia, morphia, &c.—for hypodermic use were found to dissolve completely, as a rule not more than from two to three minims of water being required.

The Reporters were much struck by the scientific skill and accuracy displayed in the manufacture of all the articles and preparations.

Every operation was conducted under the immediate superintendence of a scientific chemist, and it was felt that every effort had been made to ensure the highest degree of perfection.

This report must be regarded as merely provisional, but Messrs. Burroughs, Wellcome, & Co. are to be congratulated on the favourable impression their articles have evidently made on the Commissioners.

The extensive new factory and laboratories erected by Burroughs, Wellcome, & Co. are fitted up with extremely elaborate and costly machinery, and scientific, chemical, and pharmaceutical apparatus. These appear to be on a scale quite commensurate with the business connections of this firm, whose correspondence and transactions extend into every civilised country of the world. The vacuum apparatus for preparing the Kepler Extract of Malt is the largest one ever constructed, and is of an original design—the invention of the members of the firm. By the use of this apparatus Extract of Malt is prepared at a lower temperature than is possible by any other: this is the secret of the superiority of the Kepler Extract. The condensing apparatus, percolators, mashing tubs, malt mills, air pumps, filter presses, mixing apparatus (for preparing the Kepler Emulsion of Malt and Oil) are all unique, and of improved designs.

One section of the buildings is devoted to the manufacture of the Compressed Tablets, in the process of which extremely intricate machinery is required.

It would occupy too much space to enumerate all the complete equipments of these extensive laboratories, which bear every evidence that the proprietors keep fully up to the times in all scientific improvements pertaining to pharmaceutical manufactures. A boiler of 40 horse-power and an engine of 24 horse-power are required to operate the machinery, while the extensive manufactures necessitate the use of upwards of 50,000 gallons of water per day, and in order to secure this of great purity artesian wells have been sunk.

Messrs. Burroughs, Wellcome, & Co. are both graduates of the oldest Pharmaceutical College in the world, and their laboratories are presided over by a scientific chemist of exceptional attainments.

NEW IMPROVEMENTS IN PHARMACY.

THE KEPLER EXTRACT OF MALT.

(CONCENTRATED AND NON-ALCOHOLIC.)

THIS Extract of Malt has steadily grown in the favourable estimation of the medical profession since its introduction to them as the leading pioneer preparation. The aim of the manufacturers of the Kepler Extract has been to produce the best possible article, and they have spared no expense in costly scientific apparatus, machinery, and appliances.

By their new process, which includes evaporation at an unusually low temperature, *all* of the *diastase* is fully preserved, and the Kepler Extract will be found *unequalled* in its power of digesting starchy or farinaceous foods, and as an article of diet in wasting diseases.

'Kepler Extract is liked by patients, and often taken readily when other forms are not retained. It is a good plan to begin with a teaspoonful three times a day, but the dose may be rapidly increased to a tablespoonful or more. One of the best vehicles for taking the Extract of Malt is a little warm milk; but some people prefer it alone, whilst others like it with soda-water. It speedily improves the powers of assimilation, and in cases of consumption, scrofula, and many of the wasting diseases, especially of children, a wonderful improvement in the patient's condition may be noticed after even a fortnight's treatment. The introduction of Kepler's Extract of Malt is a decided advance in therapeutics.'—Report of the *London Medical Record*.

The *Lancet* says of the Kepler Extract of Malt:— 'The best known, and in this country the largest used Extract of Malt. It is as distinct an advance in therapeutics as was the introduction of cod-liver oil. It is one of our best nutritive and digestive agents for atonic dyspepsia, and is undoubtedly useful in consumption and other wasting diseases.' And further adds, 'It is very good, and may be used with confidence.'

'KEPLER' EXTRACT OF MALT IN COMBINATION.

LIST OF COMBINATIONS.

Kepler Extract of Malt with Cod Liver Oil.	
" " "	Beef and Iron.
" " "	Chemical Food (Phosphates Co.)
" " "	Chocolate.
" " "	Ferri Pyrophos.
" " "	Ferri et Quiniae Cit.
" " "	Ferri et Quiniae et Strychnia.
" " "	Ferri Iodide.
" " "	Cod Liver Oil and Iod. Iron.
" " "	Cod Liver Oil and Phosphorus.
" " "	Alteratives.
" " "	Hops.
" " "	Hypophosphites.
" " "	Phosphorus.
" " "	Pancreatine.
" " "	Pepsin.
" " "	Pepsin and Pancreatine.
" " "	Peptones.

Supplied in $\frac{1}{2}$ lb. and 1 $\frac{1}{2}$ lb. bottles. Maximum adult dose of any combination one tablespoonful.

Complete Formulæ will be sent post free on application; other Combinations can be prepared by any Dispenser extemporaneously using the Kepler Extract, or Oil and Extract, instead of Syrup.

THE KEPLER EMULSION OF COD-LIVER OIL WITH EXTRACT OF MALT.

THIS preparation was introduced to the medical profession by us several years ago, since which time it has steadily grown in favour as the most digestible, palatable, and efficacious form for the administration of cod-liver oil.

The oil in it is in a state of emulsion, and the particles of oil are much finer than in milk.

Medical experiments have frequently proved that in nine cases out of ten clear cod-liver oil is not fully assimilated, owing to the difficulty of digesting it in this condition. It is often voided *per anum* just as taken, and *en masse*. In such cases, it is needless to say, the oil is not only wasted, but the digestion becomes deranged in attempting to assimilate it. In this emulsified form such an untoward event is all but impossible, as in this combination the natural emulsifying process is most completely performed, all the minute particles of cod-liver oil being separated from each other, and so finely subdivided as to be readily taken up by the lacteals.

In weak digestions a fat already emulsified can be readily assimilated when the system is unequal to dealing with the simple fat.

Kepler Extract of Malt being rich in nitrogenous elements or flesh-formers, and cod-liver oil in carbohydrates or fat-producers, this compound is found to be nutritious in the highest degree, and its use to lead to a progressive increase in strength and weight.

We have high medical authorities for stating that greater benefit will usually be derived from 5 lbs. of the Kepler Emulsion of Cod-Liver Oil with extract of malt than from 25 lbs. of unemulsified oil, and even more than this in cases of weak digestion, which the plain oil is liable to aggravate, but which the Kepler emulsion will usually relieve, the extract of malt being a most valuable digestive agent.

This combination possesses great superiority over the ordinary emulsions of cod-liver oil, as usually made with gum, sugar, and water (which simply serve to dilute the oil with comparatively useless material), while the Kepler Extract of Malt, of which this contains fully 50 per cent., is pronounced superior to cod-liver oil in the majority of cases for which the latter is prescribed.

An abundance of evidence of the most positive character might be quoted to prove the desirability and advantages of this combination; but we will simply add an abstract from a report upon this subject by the *British Medical Journal*, in which the very rational conclusion is arrived at, that combined with Cod Liver Oil, Extract of Malt greatly increases the nutritive powers of the oil, renders it easy of digestion, and at the same time the taste of the oil is agreeably disguised.

Great improvements have lately been made in the machinery for producing the Kepler emulsion, and it will now be found more palatable and digestible than at any previous time.

Burroughs, Wellcome & Co. will be happy to supply a large bottle (1 $\frac{1}{2}$ lb.) free to any medical man wishing to try this preparation.

The 'Kepler' Extract of Malt, prepared from pure Barley, is greatly superior to any Malt prepared from other cereals.

The *Medical Times and Gazette* says 'the "Kepler" Extract of Malt is by far the best we have seen.'

HAZELINE.

Active principles distilled from the fresh green bark of the witch-hazel (Hamamelis Virginica).

Medical properties:—Anodyne, sedative, tonic, styptic, antiseptic, astringent, and refrigerant.

Hazeline is quite free from poisonous or irritating properties, and is employed both internally and externally in inflammatory, suppurating, and painful conditions generally.

DIRECTIONS FOR USING HAZELINE.

For *bruises, burns, wounds, abrasions*, and for *varicose inflammations and sores*, Hazeline may be applied undiluted by means of bandages or Lawton's Absorbent Cotton.

For *hemorrhoids* the best method is to administer from ten to thirty drops daily, and at the same time employ it as an injection, clear, or diluted with an equal bulk of water, or it may be applied frequently as a lotion with Lawton's cotton.

In *hemorrhages* (especially passive), and in *diarrhæa, dysentery*, and *inflammation of the bowels*, from ten drops to half-a-teaspoonful should be taken frequently till relieved.

In *menorrhagia, amenorrhæa*, and *leucorrhæa* it may be injected and also taken in twenty-drop doses frequently.

In *inflammation of the lungs, pleurisy, asthma, bronchitis*, and *sore throat*, it is best used as a spray or in atomizer, also applying it externally.

In *osena and ordinary catarrh* it may be snuffed up the nostrils, diluted with equal bulk of warm water, or applied by means of a camel's hair pencil or a spray.

In *purulent ophthalmia and inflammation of the eyes*, it may be diluted with an equal bulk of warm water, and applied by means of Lawton's Absorbent Cotton.

For *ulcerated sore mouth, tender gums, toothache, and bleeding sockets*, Hazeline may be employed as a mouth wash.

The *Lancet* says of Hazeline:—'It is as good as it is attractive, and deserves a much more extensive trial than it has yet received.'

COMPRESSED TABLETS.

Manufactured by Burroughs, Wellcome, & Co.

'The Compressed Tablets are a great improvement on the hard, unpalatable lozenges which have so long done duty in the Pharmacopœia.'—*The Lancet*.

Ammon. Bromid. Tablets ..	5 and 10 gra.
Ammon. Chlorid. Tablets ..	3, 5, and 10 gra.
Ammo. Chlorid. with Borax ..	1-2 gra. of each.
Bismuth. Sub-Nit. Tablets ..	5 gra.
Cathartic Compound Tablets ..	(U.S.P.F.)
Cinchonidia Salicylate Tablets ..	2 gra.
Dover's Powder (pecc. Comp.) ..	5 gra.
Ipecac. Tablets ..	3 gra.
Lithii Carb. Tablets ..	5 gra.
Peptonic Tablets ..	
Pepsin, Pancreatin, Lacto-Phos. Lime ..	
Pot. Nit. (Sal. Prunella) ..	5 gra.
Potass. Bicarb. Tablets ..	5 gra.
Potass. Chlorate Tablets ..	5 gra.
Potass. Chlor. with Borax ..	1-2 gra. of each.
Potass. Permanganate Tablets ..	1 and 2 gra.
Potassi Bromid. Tablets ..	5 and 10 gra.
Potassi Iodid. Tablets ..	5 gra.
Quinine (Soluble) Tablets ..	1, 2, 3, and 5 gra.
Soda-Mint (or Neutralizing Tablets) ..	
Soda Bicarb. 4 gra.; Ammon. Carb., 1-4 gr.; Ol. Ment. Pip., 1-5 gr.	
Sodæ Bicarb. Tablets ..	5 gra.
Sodæ Chlorate Tablets ..	1 gr.
Sodæ Chlorate with Borax ..	1-2 gra. of each.
Sodii Bromid. Tablets ..	5 and 10 gra.
Sodii Iodid. Tablets ..	5 gra.
Sodii Salicylate Tablets ..	3 and 5 gra.

COMPRESSED TABLETS (cont.)

These Compressed Tablets contain only the pure drug as specified without any addition or excipient whatever.

Those which are usually employed for local effect upon the throat, as chlorate, potash, &c., are made very hard and dissolve slowly, while those intended for internal administration, as Soluble Quinine Tablets are so compressed as to dissolve readily, and are in fact much more soluble than ordinary Quinine pills. The compressed form is much easier swallowed than the round form of pill, and is also the smallest pill it is possible to make from a given quantity of drug.

The Compressed Tablets keep well in all climates.

HYPODERMIC TABLETS.

(Compressed and Soluble.)

Manufactured by Burroughs, Wellcome, & Co.

We claim for the Hypodermic Tablets—

Absolute Accuracy of Dose—Ready and Entire Solubility—Perfect Preservation of the Drug.

The *Lancet*:—'They are very soluble and not at all irritating.'

Their convenience and utility will at once be apparent on examination.

Aconitia ..	1-260 gr.
Aconitia ..	1-130 gr.
Apomorphia ..	1-10 gr.
Atropiæ Sulphas ..	1-150 gr.
Atropiæ Sulphas ..	1-100 gr.
Atropiæ Sulphas ..	1-60 gr.
Digitalin ..	1-100 gr.
Hydrarg. Perchlor. ..	1-60 gr.
Hydrarg. Perchlor. ..	1-30 gr.
Morphiæ Bi-Meconate ..	1-8 gr.
Morphiæ Bi-Meconate ..	1-6 gr.
Morphiæ Bi-Meconate ..	1-4 gr.
Morphiæ Bi-Meconate ..	1-3 gr.
Morphiæ Sulphas ..	1-12 gr.
Morphiæ Sulphas ..	1-8 gr.
Morphiæ Sulphas ..	1-6 gr.
Morphiæ Sulphas ..	1-4 gr.
Morphiæ Sulphas ..	1-3 gr.
Morphiæ Sulphas ..	1-2 gr.
Morphiæ Sulphas and Atropiæ Sulphas ..	1-12 gr.
Morphiæ Sulphas ..	1-250 gr.
Morphiæ Sulphas and Atropiæ Sulphas ..	1-8 gr.
Atropiæ Sulphas ..	1-200 gr.
Morphiæ Sulphas and Atropiæ Sulphas ..	1-6 gr.
Atropiæ Sulphas ..	1-180 gr.
Morphiæ Sulphas and Atropiæ Sulphas ..	1-4 gr.
Atropiæ Sulphas ..	1-150 gr.
Morphiæ Sulphas and Atropiæ Sulphas ..	1-3 gr.
Atropiæ Sulphas ..	1-120 gr.
Morphiæ Sulphas and Atropiæ Sulphas ..	1-2 gr.
Atropiæ Sulphas ..	1-100 gr.
Pilocarpin ..	1-10 gr.
Pilocarpin ..	1-3 gr.
Pilocarpin ..	1-2 gr.
Strychniæ Sulphas ..	1-150 gr.
Strychniæ Sulphas ..	1-100 gr.
Strychniæ Sulphas ..	1-60 gr.

IN THE NEW POCKET CASE for Soluble Compressed Hypodermic Tablets there is space for from three to twelve tubes of tablets, also for a syringe, needles, and small mortar and pestle for readily crushing and dissolving the tablets. The whole can be carried in the vest pocket.

Price of Case, 5s.; Syringe and two Needles, 7s.; Mortar and Pestle gratis; Tubes of twelve Tablets, 1s. each. Burroughs, Wellcome, & Co.

CAPSULED PILLS 'McK. & R.'

To the Medical Profession.—

To secure the dispensing of these improved Pills for your patients it is essential to specify them as above for the guidance of the chemist who receives the prescription.

All of the Pills and Formulæ on the following list are now kept in stock by the leading chemists in principal towns throughout the world, and may be readily obtained by all chemists from their regular wholesale drug houses.

If any of the dispensing chemists in your locality are unfamiliar with this new and improved form of drugs, will you kindly allow them to examine this list.

LIST OF FORMULÆ

Of the British Pharmacopœia and other Standard Authorities.

Purest Quality and Exactness in Composition can be relied upon with confidence by the Profession. Put up in Bottles containing 100 each.

- PIL. Aloes Barb. B.P.** (McK. & R.) 5 gr.
Aloes, Dilute (Dr. Hall's Dinner Pill). (McK. & R.) 4 gr.
 Aloes Barb. Pulv. Ext. Glycorr. Pulv. Theriacæ, aa, 1-4 gr.
Aloes, Sootrine, B.P. (McK. & R.) 5 gr.
Aloes and Assafœtida, B.P. (McK. & R.) 5 gr.
Aloes and Iron, B.P. (McK. & R.) 5 gr. ;
Aloes and Myrrh, B.P. (McK. & R.) 3 gr.
Aloes and Myrrh, B.P. (McK. & R.) 5 gr.
Aloine. (McK. & R.) 1 gr.
Arsenious Acid. (McK. & R.) 1-50 gr. |
Assafœtida Comp. B.P. (McK. & R.) 5 gr.
Osali Sulphid. (McK. & R.) 1-10, 1-4, and 1-2 gr.
Osalmel, Colocynth, and Hyoscyamus. (McK. & R.)
Osalmel Comp. B.P. (McK. & R.) 5 gr. |
Osalmel and Opium. (McK. & R.)
CAMPHOB, MONOBROMIDE. (McK. & R.) 2 gr.
Cathartic Comp. U.S.P. (Purgative). (McK. & R.)
 Ext. Jalapæ. Pulv., 1 gr. Ext. Coloc. Co. Pulv., 1, 1-3 gr. Hyd. Subchlor., 1 gr. Gambogia Pulv., 1-4 gr. A very popular prescription.
Cholera. 2 gr.
 Opil, 1 part. Capsici Piper Mg. Camphor Assafœtida, aa, 4 parts.
Colocynth Comp. B.P. (McK. & R.) 4 gr.
Colocynth Comp. B.P. (McK. & R.) 5 gr.
Colocynth Comp. and Osalmel. (McK. & R.) 5 gr.
Colocynth Comp. et Hydrarg. B.P. (McK. & R.) 5 gr.
Colocynth and Hyoscyamus. (McK. & R.) 5 gr.
Conil Comp. B.P. (McK. & R.) 5 gr.
Copaiba and Cubebs. (McK. & R.) 5 gr.
Oroton Chloral. 1 gr. and 2 gr.
DIGITALIN. (Pure Crystal.) (McK. & R.) 1-60 gr.
Ext. Colocynth Comp. B.P. (McK. & R.) 5 gr.
EBGOTIN. (McK. & R.) 3 gr.
Each Pill contains the active principles of 30 grs. Ergot of Rye.
Euonymin. (McK. & R.) 1 gr. and 2 gr.
Euonymin Comp.
 Euonymin, 1 gr. Aloin, 1 gr. Ext. Nux. 1 gr. Ext. Hyosciam., 1 gr. Ext. Rhei, 1 gr.
Ferri Carb. B.P. (McK. & R.) 5 gr.
Ferri et Quinise Cit. B.P. (McK. & R.) 2 gr.
Ferrum Redactum. (McK. & R.) 1 gr.

The *Lancet* says:—'The one form of pill that is an improvement upon anything previously manufactured.'

CAPSULED PILLS 'McK. & R.' (cont.)

- Pil. Ferruginous.** (Blaud's.) (McK. & R.) 3 & 5 gr.
Hydrarg. B.P. (*Blue Mass.*) (McK. & R.) 1, 2, 3 & 5 gr.
Hydrarg. Coloc. et Hyoscy. (McK. & R.)
Hydrarg. Iod. Rub. (McK. & R.) 1-16 gr.
Hydrarg. Iod. Vir. (McK. & R.) 1-4 gr.
Hydrastia (White Alkaloid). (McK. & R.) 1-2 gr.
Ipecac. Comp. Pulv. (McK. & R.) 5 gr.
Ipecac. and Squills, B.P. (McK. & R.) 5 gr.
Iodoform. (McK. & R.) 1 gr.
Laxative, Vegetable (Imp. Cathartic). (McK. & R.)
 Res. Podoph. Ext. Hyoscy. Ext. Tarax., aa, 1-4 gr.
 Ext. Coloc. Co. Pulv., 1 gr. Jalapæ Pulv. Res. Leptand., aa, 1-2 gr. Ol. Menth. Pip. Dose—one to three.
Morphia, Hydrochlor. (McK. & R.) 1-8 & 1-4 gr.
Nitro-Glycerine. 1-50 & 1-100 gr.
Opium. (McK. & R.) 1 gr.
Pepsin, Pure, Concentrated. (McK. & R.) 1 gr.
 Each Pill equal in digestive properties to 3 gr. Pepsin, B.P.
PHOSPHORUS. (McK. & R.) 1-30, 1-50, & 1-100 gr.
 The pure, free Phosphorus is in a state of solution in the excipient we employ.
Phosphorus and Iron. (McK. & R.)
 Phosphor. Pur. 1-50 gr. Ferri Redact. 2 gr.
Phosphorus, Iron, and Quinine.
 Phosphor. 1-100 gr. Ferri Carb. 1 gr. Quinia, 1 gr.
Phosphorus, Iron, Quinia, and Strychnia.
 Phosphor. 1-50 gr. Quinia, 1-2 gr. Ferri Red., 2 gr. Strych. 1-60 gr.
Phosphorus and Nux Vomica. (McK. & R.)
 Phosphor. Pur. 1-50 gr. Ext. Nux Vom. 1-4 gr.
Phosphorus, Nux Vomica, and Iron (McK. & R.)
 Phosphor. Pur. 1-50 gr. Ext. Nux Vom. 1-4 gr. Ferri Carb. 1 gr.
Phosphorus and Quinine. (McK. & R.)
 Phosphor. Pur. 1-50 gr. Quinia Sulph. 1 gr.
Phosphorus and Valer. Zinc. (McK. & R.)
 Phosphor. Pur. 1-50 gr. Zinci Valer. 1 gr.
Plumbi et Opio, P.B. (McK. & R.) 5 gr.
PODOPHYLLIN. (McK. & R.) 1-4 & 1-8 gr.
Podophyllin Comp. (McK. & R.)
 Podoph. Res. 1-2 gr. Ext. Coloc. Co. 2 gr. Ext. Hyoscy. 1 gr.
QUINIA, BI-SULPH. (Soluble Sulphate). (McK. & R.)
 1-4, 1-2, 1, 2, 3, 4 & 5 gr.
 This is much superior (on account of greater solubility) to the ordinary Sulphate of Quinine.
Quinia Comp. (Anti-Malarial). (McK. & R.)
 Quinise Sulph. Acid. Carbolic. Cinchonid. Sulph., aa, 1 gr. Menth. Camphor. 1-8 gr. Acid. Ansa. 1-10 gr. Capsici Pulv. 1-4 gr.
Rhei Comp. B.P. (McK. & R.) 5 gr.
Rhei Comp. et Hydrarg. (McK. & R.)
 Pil. Rhei Comp. 3 gr. Pil. Hydrarg. 3 gr.
Salicylic Acid. (McK. & R.) 2 & 5 gr.
Salicylic Acid, Comp. (Rheumatic). (McK. & R.)
 Acid Salicylic, 5 gr. Morphia Hydrochlor. 1-8 gr.
Saponis Comp. B.P. (Pil. Opil.) (McK. & R.)
Squills Comp. B.P. (McK. & R.) 5 gr.
Strychnia. (McK. & R.) 1-50 gr.
Zinc Valerianate. (McK. & R.) 1 gr.
Zinci Phosphide. (McK. & R.) 1-4 & 1-8 gr.
 The dash is used to denote fractions, as 1-2 for one-half.

Private formulæ of 3,000 or more pills prepared to order.

Dispensed by all chemists in the ordinary way, by the dozen pills, more or less.

'The ovoid shape is a positive advantage over the round form, as patients, even small children, take them easily after finding it impossible to swallow round pills, even if coated. These pills are completely and hermetically sealed by the continuous covering of gelatine. They are quickly soluble, and certainly the most important improvement yet made in the manufacture of pills.'—*Medical Press and Circular.*

For complete Formulæ List and Therapeutic Notes, see *The Lancet*, March 31, 1883.

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

ON THE DISPOSAL OF TYPHOID EXCRETA BY CREMATION.

By PROFESSOR ANDERSON STUART, M.D., Hon. Physician to Hospital for Sick Children, Sydney.

SOMETIME ago, owing to the prevalence of typhoid fever amongst the nurses and servants at the Hospital for Sick Children at Glebe Point, it was resolved to discontinue the burial of the typhoid excreta in the garden of the hospital. It is by no means proved that this had any considerable share in the production or propagation of the disease in the hospital, but yet it did not seem desirable any longer to continue the burial of so much infectious matter in such a very limited area, and so close under the windows of the institution.

It was resolved to have all the nightsoil from the institution carted away by the night-carts. But this is a costly mode of getting rid of it, and, moreover, the carts have not proved agreeable visitors at untimely hours of the night. Nor is this a perfect means of disposing of the excreta, for, although removed from the hospital, they are simply taken somewhere else—not destroyed or rendered harmless.

It occurred to me some six months ago that if we could burn the excreta, we would effectually destroy them. I thought, also, that with apparatus suitable as to size we would even be able to burn all the excreta from the whole hospital, and thus not only effect a sanitary improvement, but also a pecuniary saving.

By the crematorium, which I shall presently describe, I succeeded in dealing effectually enough with the stools, but there is one drawback, and though one only, it may yet altogether prevent the realization of my ideas. It is this: the organic matter yields chemical substances, products of destructive distillation and combustion, which, though non-infective, are yet most unpleasant to the sense of smell. The urine, which it is so difficult to keep from mixing with the faeces in the cases of children, is much the greater offender in this respect. Those who have worked in a laboratory, where urine was being evaporated only, will be able to imagine the disagreeable nature of the odour; even a milder form of the odour, in the shape of a woollen rag burning in the open fire, will be sufficient to bring home to us the nature of the smell. I do not think the

faeces contribute much to the odour, it is as purely urinous.

In my design I did not neglect this matter, but I thought that I would be able, by comparatively simple means, to raise the temperature of the gases so high that the end products of their combustion and dissociation would be comparatively odourless.

If the method is to be successful in practice, I fear we will have to devise some means of keeping separate the urine and the faeces, or of heating the gases so high that they become odourless. It will also be important to carry the chimney so high that, ere the gaseous products come to levels or places occupied by the inhabitants of the district that, if odorous, they would yet be so diluted by mixture with the air that they would no longer be disagreeable.

Of course there is a large imagination element in the "*badness*" of the odour. The smell of the burning organic matter has been associated with the faeces and urine in the retort, and with the typhoid disease itself, and the association of these three bad things has led to much of the odour perceived being subjective.

The stools to be destroyed are emptied into a cast iron retort, where they remain until a sufficient charge has been accumulated.

When the fire is lighted the water is first driven off as steam, and when the water has all evaporated the residue naturally rises in temperature so as to be completely charred.

The retort is in the centre of the space enclosed by the outer jacket of the crematorium. This space is subdivided by a nearly vertical diaphragm into an anterior and posterior chamber, which communicate over the top of the retort. The chimney arises from the lower part of the posterior chamber. Thus the products of combustion of the fire pass up along the front side of the retort, and down along the other side before they escape by the chimney.

The exit tube of the retort (which corresponds to the "*worm*") rises out of the top of the retort, descends in the posterior chamber, bends forwards, pierces the lower part of the diaphragm, and so enters the anterior chamber, where the vaporous and gaseous matters emerge by a series of little perforations in the tube just under the furnace.

When they emerge from the tube under the fire, they are caught by the draught and carried through the fire over the red-hot fuel, and through the flame and hot air currents, with which they mix and pass over and round the retort to escape by the chimney.

While in the exit tube they become superheated by the furnace draughts, and while in the fire they should undergo a maximum of change.

Thus, I imagined that the infective matters would be reduced to odourless gases and carbon, and although as yet the plan is not entirely successful, still I am convinced that this is a step in the right direction. That it might succeed we know from the numerous successful cremations of entire human and other bodies, and in the neighbourhood of inhabited localities.

In last month's *A.M.G.* I note that a plan, somewhat similar to mine, has been suggested by Dr. John Reid, of Port Germein, S.A. He says that thus we "would probably soon rid these colonies of the scourge," and I am inclined to go a considerable way in agreement with this opinion.

In a place reeking with typhoid fever, as Sydney and its suburbs undoubtedly are, this question of the disposal of typhoid excreta is one of high importance. What can we expect from the numerous cesspits in the suburbs, practically one to every house, into which the typhoid excreta must in most cases ultimately find their way, but that typhoid fever should exist and flourish in our midst—a pestilence more grievous than smallpox. But, because more mysterious in its coming, more insidious in its onset, less violent in its presence, less provocative of commotion in the public mind.

Look also at the filthy gutters of our otherwise beautiful suburbs! I do not say that they are likely to generate the organisms of typhoid fever, but it can, I think, scarcely be doubted that if typhoid is in the neighbourhood—and in what neighbourhood is it not?—that if typhoid is in the neighbourhood, then these open sewers are a suitable nidus for the organisms, whatever they are, and hence would be potent propagators of the fell disease.

I can hardly believe that any practicable means short of cremation will be entirely successful. To mix these viscid mucons discharges thoroughly enough to obtain full contact of antiseptic and fæces is, even when honestly tried, and I fear that from the nature of the circumstances this is not often the case, not an easy matter; and even admitting that some of the antiseptics in common use for this purpose are thoroughly efficient without this perfect contact they fail in the object for which they are used.

I intend to lead the chimney of my crematorium into one of the house chimneys in the hope that the dilution of the malodorous gases may be sufficient to render them not disagreeable to persons in the vicinity while the process is being carried out.

Possibly when the Nepean supply of water comes, and we have a system of drainage, these measures may be less needed, but we may have to wait long for this, and our need is immediate.

And in how many of our towns in the interior will we ever have an efficient system of drainage? and yet the scourge is there too.

GINE'S CURE FOR TONSILLITIS.

By THEO. M. KENDALL, B.A. SYD., L.R.C.P.
ET R.C.S., EDIN., LATE SENIOR ASSISTANT
SURGEON, ST. VINCENT'S HOSPITAL.

No disease is more painful, or causes so much discomfort as Tonsillitis. Probably no other disease has called forth more remedies.

Gargles, inhalations, mixtures taken internally, and bleeding, have all been tried with varied success, in attempts to cure or alleviate this disease. Aconite and belladonna have been used with varied success in the attempt to cut short an attack. Tanner lauds belladonna highly, and recommends guaiacum in cases of a gouty nature. Other good writers recommend a passive, rather than an active treatment, and among these is Trousseau, who recommends that we should rather treat symptoms as they arise than take any energetic steps to arrest the course of the disease. The French surgeon, Louis, states that, out of twenty-three cases, thirteen were bled, and ten were not, the result being that bleeding shortened the duration of the disease by one day.

A short paragraph which recently appeared in the *British Medical Journal*, set forth the valuable properties of bi-carbonate of soda in the treatment of Tonsillitis, and recommends it on account of its great simplicity.

I have, myself, been in the habit of using this drug for the last four years; and as yet it has never failed to produce a good result. The remedy was introduced to the profession by M. Gine of France. He claimed that by the use of the drug he was able to cut short an attack of Tonsillitis twenty-four hours after the first application of the powdered salt to the tonsil. Such a rapid cure has, however, never occurred in my practice, but I have had very good results in thirty-six hours and forty-eight hours, although in elderly people the attack has lasted five or six days. The drug is, I think, well worthy of the attention of the profession on account of the absence of baneful properties, and is without doubt useful in cases of inflammatory sore throat, due to the influence of cold on an exhausted nervous or muscular system.

50 Macleay Street,
Darlinghurst, Sydney.

CASE OF HYSTERICAL AMBLYOPIA IN A GIRL 13 YEARS OF AGE.

By W. ODILLO MAHER, M.D., M.Ch., M.R.C.S.;
SYDNEY, LATE HOUSE SURGEON ROYAL
LONDON OPHTHALMIC HOSPITAL, MOOR-
FIELDS.

A.C., aged 13 years, a strong, healthy, intelligent orphan girl, was brought to me on the 5th of March by her guardian, who stated that her charge was totally blind in the left eye. This she discovered a fortnight previous, when one evening, thinking the child's left eye looked smaller and redder than usual, she requested her to cover it with her hand, and asked her what she could see with the right eye. The child replied she could see perfectly well. She then told her to cover the right eye, and, to her astonishment, discovered that the child could not see to pick up a lighted candle which was upon the table. She also tested her with large print, which, of course, the child could not see. From that time, until she consulted me, there had been no alteration in vision.

The child's previous history was unimportant, except that she had never menstruated.

On examination were found—

Left Eye: The *Eyelids*, with Sycosis Tarsi; *Conjunctiva*, normal; *Sclerotic*, normal; *External Muscles*, normal; *Cornea*, small nebula at lower edge of pupil; *Ant. Chamb.*, normal; *Iris*, normal; *Pupil*, direct and indirect action to light good, also acted well to accommodation; *Lens* and *Vitreous*, normal; *Fundus*—this I examined most carefully, with the pupil widely dilated (Sol. of Atrop., grs. iv. ad $\frac{3}{4}$ i.), and failed to discover anything abnormal. No dilatation of blood-vessels nor serous transudation into the retina, as has been described in these rare cases by Landolt; *Vision*, bare perception of light; *Refraction*, as

tested by Retinoscopy—
$$\frac{H+1.5D}{\sqrt{+1.75D}}$$
 showing slight hypermetropic astigmatism, which should be corrected by
$$\frac{+ .5D \text{ sph.}}{+ .25D \text{ cyl. axis horl.}}$$
 Field and

Perception of Colour, nil; *Tension*, normal.

The *right eye* was perfectly healthy; *Vision*, $\frac{3}{4}$; and Jaeger, 1.

The history of the case, together with the absence of Fundus changes, left no room for doubt as to the diagnosis.

I prescribed for the Sycosis, and advised that the child, who was living in one of the suburbs, should remain in town under the care of some friends, so that she might have a complete change of scene.

I did not again see the patient for a week,

when her guardian informed me, with much pleasure, that the sight was returning.

On questioning the child, she told me that the day after her first visit the sight began gradually to return, and had since been daily improving.

On examination I found she could see $\frac{3}{4}$ and J1 with the previously blind eye, and the following day vision was normal, $\frac{3}{4}$ and J1.

The Field and colour perception were perfect.

I regret that on the occasion of her first visit I did not examine for hemianæsthesia, which is often present in these cases. There was no hemianæsthesia when she paid her second visit.

Whilst House Surgeon at Moorfields, I had under observation a little girl twelve years of age, whose case was almost identical with the preceding. She was totally blind in the right eye, and, after three weeks treatment as an in-patient, made an equally satisfactory recovery.

SANDY BLIGHT.

By JOHN REID, M.A., M.B. ET CH.M. ABERD.,
OF PORT GERMEIN, SOUTH AUSTRALIA.

WHAT has been represented to me as sandy blight occurs either in a chronic form or acute. In either case there is at first a feeling of grittiness of the eyelids, and when acute the conjunctiva is chemosed, lids are red, shining, and cedematous (e.g., Purulent Ophthalmia, Lawson's Dis. of Eye, 1880, p. 8), and there is a considerable amount of photophobia. I may add that the last named symptom frequently leads to the diagnosis of strumous ophthalmia in youngsters. The mouths of the meibomian glands, however, show pus of a tough character, exuding and passing into the eye as the real cause of the grittiness, &c., especially when on everting the lids the swollen glands are observed. The pus from the eye is also very tenacious, and I may add that some cases end in ulcerated cornea. The eye secretion is acid. Cultivations of pus in gelatine have in all my cases examined, exhibited a growth like a spider's web closely woven, and growing in one plane. Microscopically the pus and cultivations show bacilli and spores.

Treatment.—Morphia and purgatives internally alone seemed to give relief in very acute cases. Some are cured or become chronic by aconite topically. Calomel powder to eye, weak carbolic atropia, hazeline, astringents, and AgNO₃ (grs. ii. ad $\frac{3}{4}$ i.) seem to act well. When chronic, ungt. hydrarg. oxid. Rubr., &c., seem to act well, especially if a gland has been stopped up for a short time and formed a cyst.

NOTES OF A CASE OF EMPYEMA AND PNEUMOTHORAX, WITH DISCHARGE OF PUS THROUGH LUNG, TREATED BY FREE INCISION AND WASHING OUT OF PLEURA—COMPLETE RECOVERY.

UNDER THE CARE OF A. SHEWEN, M.D., LOND.,
HON. PHYSICIAN PRINCE ALFRED HOSPITAL,
SYDNEY.

THIS patient, J. K., first noticed a shortness of breath in '79, when he consulted a medical man, who said he had pleurisy; he got a little better, but did not regain his strength or appetite. For the next four years he was under first one medical man and then another, until at last one of them sent him to this hospital, where he was admitted shortly before Christmas, 1883.

On admission he stated that he had lost four stone in weight, and when examined he was found to be extremely emaciated, and presented all the signs of having fluid within the left pleural cavity. An exploratory puncture having been made, a hypodermic syringe of dark brown purulent fluid was drawn off. Afterwards, about a pint of the same fluid was aspirated from his chest. He stayed in the hospital for some four or five weeks, when, as he did not seem to be making much progress either one way or the other, he was discharged, with instructions to return in a week or two for examination. After remaining out for some three weeks he returned, February 18, 1884, to the hospital, and said that he had been spitting up enormous quantities, "quarts," of the same brownish fluid which he had drawn from the pleura by means of the aspirator.

He was at once re-admitted, and on examination it was found that he was still more emaciated than before.

The physical signs on February 18th were as follows—absolute dullness in left axilla, with almost total absence of respiratory murmur and vocal fremitus; left base not absolutely dull, but great loss of vocal fremitus.

February 26—Much same condition, but sweats a great deal and expectorates large quantities of brownish muco pus; has been having inhalations of iodoform, with maltine and cod liver oil, and atropia for night sweats. The heart is now displaced to right, and the beat is most forcibly felt in the epigastric region.

March 2.—The dullness left side as before, with total absence of vocal vibrations. On setting the patient up there is hyperresonance extending as far as the level of rib iii. in front. On auscult-

ing, distinct splashing can be heard, and the bell sound is beautifully marked. The patient is aware of the splashing sound within his chest.

An exploratory needle was introduced, and thick purulent matter withdrawn; and after consultation it was decided to make a free opening into chest, to evacuate the contents, and then to thoroughly wash out the cavity. Mr. Hankins made an incision between ribs v. and vi. in the axillary line, left side—a great quantity of very offensive dirty brown purulent fluid was evacuated. A drainage tube, ten inches long, was then introduced, and the cavity was well syringed out with carbolic, 1 in 40. During this treatment the patient had several severe attacks of coughing and dyspnoea, and distinctly tasted the carbolic lotion. The washing out was continued till the fluid came away quite clear, and the wound was then dressed with cotton wool, moistened with eucalyptus lotion, and sprinkled with powdered iodoform. It is well to add that the patient's temperature previous to the operation had been always above the normal—on the evening of the operation it was 101 deg.; pulse 90; respirations 36; bowels constipated.

March 3.—Patient had a fair night, and feels easier this morning—temperature 100 deg., pulse 80; a considerable amount of discharge on the dressing; washed out three times during the day with saturated boracic lotion; much irritation caused by the washing out.

March 4.—Had a very good night, T. 99.4; P. 81; R. 28; not so much discharge; heart's apex nearly in normal situation.

March 5.—Had a restless night, temperature normal this morning, and very little discharge from the wound; chest washed out three times during the day with carbolic lotion.

March 9.—Not so well; temperature 102 deg., pulse 100, R. 80; complains of pain in the left side. There is some local irritation in the neighbourhood of the wound, with erythema and exuberant granulations.

March 11.—The left side is collapsing, and on auscultation some air seems to be entering the lung; the patient, however, still maintains he can taste the fluid that is used for washing out, and remarked on the bitterness of a lotion of quinine when it was employed.

March 29.—The temperature has now been normal since the 19th, and the patient is in everyway very much better; there is a good deal of deformity on the left side, and if the washing out is not regularly and carefully continued, there is a good deal of accumulation of offensive discharge.

April 4.—Temperature rose to 100 deg.; the tube was found to be blocked up with small

gelatinous cysts, and when the tube was cleaned thirty to forty more cysts came away; they resembled small hydatids, but a careful microscopic examination failed to reveal any hooklets.

April 7.—A few more cysts came away; the patient is really better, but has been for some time in a miserable melancholic condition, and has quite made up his mind he will not recover. All through the remaining days of April and the whole of May the same treatment was carefully followed, and the chest was well washed out, and the temperature kept normal, and the general condition of the patient vastly improved. On June 9th the temperature rose to 102 deg., and it was found that there was some local irritation in the neighbourhood of the wound with erythema. The temperature was normal again on June 11th; the cavity held far less fluid, and no irritation was set up during the syringing, and there was no taste in the mouth, so the wound in the lung had evidently healed up. From this time, June 11th, till his discharge on July 27, the patient made rapid progress, and put on flesh quickly. On July 21 the tube which had been gradually shortened was withdrawn, there being no discharge worth speaking of. On July the 24th, no discharge at all, and a probe could not be passed into the wound. On July the 27th the patient left for "Little Bay Coast Hospital."

On the 12th of November the patient was examined and the following notes taken:

Good resonance anteriorly; posteriorly vocal fremitus equal on both sides. Heart's impulse 1 in. below nipple, and 2 in. inside; expansion of left chest much less than right; some deformity, but much less than would be expected. Resp. left, good to axillary fold, thence to axilla faint; behind, resp. below spine of scapula is high pitched, otherwise normal. Vocal resonance increased below scapula almost amounting to whispering pectoriloquy. Appetite good, is quite fat, looks well, no cough, very little shortness of breath; weight now, 10st.

REMARKS.—The chief interest in this case is the unmistakable fact that there was a free passage of fluid through the lung from the external wound to the mouth. The dyspnoea which the first washing out caused was very severe, as might have been anticipated. The extent to which the lung has recovered itself is also very interesting. Whether this was really a case of hydatids it is impossible to say, but the discharge of cysts at one stage of the case makes it probable that they were the foundation of the disease from which the man suffered.

For the notes in this case I am largely indebted to Dr. Jenkins and Dr. Roberts of Prince Alfred Hospital.

CARCINOMA OF UTERUS.

By WILLIAM T. HAYWARD, M.R.C.S.E.,
L.K.Q.C.P., IREL, OF NORWOOD, NEAR
ADELAIDE, S.A.

Mrs. G., aged 50, a wiry, energetic little woman, consulted me on October 20th, 1884, complaining of menorrhagia. She has been twice married and has had eight children, six by her first husband and two by her present one; the youngest is now nine years old. Had noticed that during the last two years she had lost more at her menstrual periods than she used to, and latterly, that they had occurred irregularly. She had no pain. Until two years ago the menses had always been regular and normal in character. Had always enjoyed very good health and made a good recovery after confinements. With the exception of above complaint her health was good. Ordered a mixture containing ergot and opium.

On November 22nd patient again consulted me, saying that while driving from the Hills into Adelaide, she had been suddenly attacked with profuse vaginal hæmorrhage. Ordered astringent mixture and complete rest in bed.

The hæmorrhage continuing, I visited the patient at her own house. I found her considerably blanched, the discharge having been excessive; it was also somewhat offensive. I advised that she should submit to a vaginal examination, but she declined.

On November 25th, the symptoms increasing rather than otherwise, I insisted on making an examination. On doing so, I found that the cervix uteri was the seat of an ulcerating epitheliomatous mass. The uterus was freely moveable, the disease, seemingly, not having implicated the fundus. The upper part of the right side of the vagina was slightly infiltrated. Considering the case likely to be benefited by extirpation of the uterus, I requested a consultation. On November 27th Dr. Gardner saw her with me and confirmed my diagnosis. We agreed that reasonable hopes might be entertained of complete recovery, if the uterus and infiltrated vagina were removed, but that it would be inadvisable to press the operation.

We therefore stated the case to the patient and her friends, giving it as our opinion that the removal of the uterus should be performed, but at the same time fully explaining the severity of the operation, but leaving it entirely to them whether the risk should be undertaken. They unhesitatingly decided to have the operation performed.

Strongly holding the opinion that operations of such magnitude should only be undertaken by surgeons of large operative experience, I requested Dr. Gardner to perform the operation, which he kindly consented to do. He has furnished me with the following report :—

"On December 11th, 1884, by the kindness of my colleague, Dr. Hayward, I had the opportunity of removing the whole uterus, per vaginam, for epithelioma of the cervix.

"Dr. Allwork gave ether, and Drs. Hayward and Corbin assisted me.

"I first grasped the anterior and posterior lips of the os uteri by long toothed forceps, to enable me to draw down and manipulate the uterus. An incision was then made through the vaginal roof, close behind the uterus, and the pouch of Douglas opened. A small incision was then made in the anterior fornix, and with the aid of a catheter in the bladder, with the occasional assistance of the fingers passed over the fundus into the vesico-uterine pouch, I managed pretty easily to dissect the bladder free in front. The cervix was then set free by an incision all round, through the mucous membrane. The uterus was then, with some little difficulty (owing to its slippery surface), retroflexed and forced through the wound in the posterior fornix. I attempted to ligature the broad ligaments with kangaroo tendon, but this would not draw tight enough, and I had to use silk at last. The uterus was then cut away, a T shaped drainage tube passed into the peritoneal cavity, and the extremities of the wound brought together. There was some oozing at first, but this soon stopped on packing the vagina with salicylic wool. During the whole operation the vagina was frequently douched with a weak carbolic lotion."

The patient was under ether for about an hour and a half; during the latter part of the time the pulse was very feeble.

8.30 p.m.—Effects of shock very considerable; surface of body cold; is sensible, and complains of a great desire to pass water; fair amount of oozing. Passed catheter and withdrew about a teaspoonful of natural coloured urine. Temp., 97.8; pulse, 116.

Ordered hot water bottles to be applied to feet and legs; weak brandy and water to be given frequently. Injected $\frac{1}{4}$ -grain of morphia hypodermically.

12.30 a.m.—Has slept comfortably; surface of body warm. Says she is easy, but complains of thirst; desire to micturate gone. Temp., 98; pulse, 136; very feeble. A teaspoonful of urine withdrawn by catheter. Ordered small pieces of ice to be sucked; a morphia suppository to be administered if uneasy.

December 11th, 8.30 a.m.—Has passed a fair night; surface of body warm; temp., 100; pulse, 120. Small quantity of urine withdrawn; the vagina syringed out with a weak carbolic lotion. There has been very little oozing; no clots in drainage tube. Pads of salicylic wool, sprinkled with iodoform, to be applied.

1 p.m.—Patient very restless; surface of body getting cold; temp., 98; pulse, 140; very feeble.

From this time she gradually became comatose, and died at 6 p.m., evidently from the effects of shock.

REMARKS.—It is only within the last few years that the operation of the removal of the uterus has come within the region of practical surgery, and even at the present day, surgeons of undoubted eminence have doubted the justifiability of the operation under any circumstances. In order to come to any sound conclusion on the subject, it is not only desirable, but is absolutely incumbent on all surgeons to report all their cases, whether they be successes or failure; and it is prompted by this feeling, that, with the full concurrence of Dr. Gardner, I have brought this case under your notice, and I trust it will have the effect of eliciting from you an expression of opinion on the subject. We have had the opportunity lately of reading in the *British Medical Journal* reports of many cases in which the operation has been performed, and also the opinions of many eminent surgeons with regard to it. This will, no doubt, have an influence on our minds, but I think we should be chary of accepting the opinion of any surgeon or surgeons, no matter how eminent he or they may be, without duly considering the question on its merits. We can none of us forget the bitter opposition to ovariectomy of thirty or forty years ago, and in later times to the operation for the removal of the uterine appendages; but there must be a limit to uterine surgery, beyond which it is unjustifiable to go. The question is, have we reached that limit, or is the removal of the uterus beyond it? This is an important question and demands our most earnest thought, for upon it depends the fate of a number of our female patients. Personally, I believe the operation is justifiable in a certain number of cases, and I have been strengthened in my opinion by the results obtained by Dr. John Wallace, of Liverpool, and published by him a short time since. But granting that such is the case, another important question arises, namely, in what cases should it be undertaken? Increased experience will alone be able to guide us to a correct opinion, but I am inclined to think that it will be limited to those cases of cancer of the uterus in which no fixation has occurred, and in which amputation of the cervix does not promise

to be successful for the cure of the disease, and in cases of fibroid tumors of the mural or extra-mural variety, that by the severity of their symptoms are causing imminent danger to life.

[NOTE.—During the last fifteen months the uterus has been removed five times in the Prince Alfred Hospital, Sydney, every case making a good recovery. This series of cases alone is enough to enable us to speak decisively in favour of the justifiability of the operation in suitable cases.—ED. A.M.G.]

THE NEW OPERATION FOR CHRONIC GLAUCOMA.

BY CHARLES GOSSE, M.D., HON. OPHTHALMIC SURGEON TO THE ADELAIDE HOSPITAL, S.A.

Miss W., aged 40, consulted me on the 27th August last year, for failing sight in the left eye. Her history was the following :—Three months ago she went to Melbourne from Fiji, for the sake of her health, which had suddenly given way. About the same time she commenced having severe headaches, and anomalous pains about her head and eyes. She was treated variously, but no one seems to have connected her symptoms with any disease of her eyes. She arrived in this colony about the 20th August, very much pulled down by the last course of treatment, namely, colchicum for supposed gout.

Present condition.—When I first saw her on the 27th instant, she was pale and nervous looking ; very much altered since I last saw her, about a year ago. She complains of pain around the left eye, and rainbows round a candle. The field of vision is much contracted, and almost entirely absent on the nasal side of the left eye.

V { L reads No. 5 S, and counts fingers at 10 feet. T. + 1.
R reads No. 1 S, and sees No. 6 S at 15 feet. T. normal.

Ophthalmoscope.—L. There is extreme cupping of optic disc, with veins distended, and arteries few and attenuated.

R. Cupping well marked, but vessels unaltered ; sight good, and she has no symptoms pointing to this eye being affected.

I ordered some Eserine drops (one grain to the ounce) to be put into the left eye, twice a day, and a tonic containing quinine. She complained of the drops irritating the eye, but still she continued them at my request.

I examined her eyes on two or three occasions between the above date and the 20th October. On the latter date I have the following entry :—Examined the left eye to-day ; field of vision blank on the nasal side, and more concentrated on the outer side, than on the 27th August ;

tension still increased ; anterior chamber quite obliterated by iris being pushed forwards ; cannot read large type, and can only see shadows.

About this time I had by me a copy of Mr. Lindsay Johnson's book on Glaucoma and its treatment, and I suggested that my patient should submit to a trial of Johnson's operation of Scleral Paracentesis.

Accordingly on the 25th October, assisted by Dr. Gardner, who administered ether, I inserted a stop speculum into the left eye, to keep the lids apart, and fixing the eye with forceps, turned it inwards, so as to expose as much as possible of the outer portion of sclerotic. I passed a knife (as near a "modified Wenzel's" as I could procure) through the sclerotic, avoiding the external rectus muscle, into the vitreous humour towards the centre of the globe. The point of the knife was entered about 4 m.m. behind the sclero-corneal junction, and penetrated about half-an-inch, the flat side of the instrument lying not quite parallel, but somewhat oblique to the long axis of the eye. The knife was then very slowly withdrawn, and slightly turned on its axis. Lymph escaped and the wound gaped, but no vitreous protruded. The speculum was removed and the eye bandaged with flannel, a small pad of lint and cotton wool being placed over each eye. On regaining consciousness she complained of a dull pain in the region of the wound ; passed a good night, but did not sleep much ; the tension of the eye normal. I ordered half a grain of opium to be taken at night.

On the fourth day after the operation I opened the eye, and the patient could see objects about the room. On looking at the wound I found it open, and occupied by a large ball of vitreous, not in the least fluid, but quite circular, and apparently caught in the edges of the wound. I immediately closed the eye, and gave a gentle rubbing with my finger on the closed eyelids, over the seat of the wound, hoping in this way to dislodge the ball of vitreous, and give a better chance of healing. She complained of a good deal of pain, and saw bright lights.

On the 3rd November she complained of a moisture about the eye, as if a dew-drop were occasionally falling down the cheek. The tension was minus, and the eye felt soft.

On the 4th November I opened the eye, and again had a look at the wound. There was still vitreous oozing, and it appeared to me to be more fluid than at first. She has had no neuralgic pains since the operation. My notes say : I confess I feel somewhat anxious about wound in sclerotic not healing ; the general health keeps low, and no desire for food ; she got up for the first time to-day.

On the 8th November I again opened the eye, and the patient could see the bell-handle on the wall, eight feet away, and large objects about the room. The wound still open, and a little escape of vitreous. The general health improving and tension normal.

Nothing of importance occurred during the next week, but the wound did not heal until the 21st day after the operation. I recommended a change to the hills, of which she availed herself, returning to town on the 18th December, with her left eye much inflamed, and the T. + 1. Severe neuralgic pains on the left side of the head, and the small amount of sight she had gained quite gone—bare perception of light.

The right eye now began to fail.

V. Reads No. 4 S and sees No. 8 $\frac{2}{3}$ S at 14 feet; T. + 1.

Glasses did not improve the vision.

Fearing to repeat Mr. Johnson's operation, as the healing of the wound had been so tedious and the flow of vitreous so continuous, I advised an iridectomy in each eye. This I did on 20th December, removing a large portion of iris directly upwards in each eye. Both wounds healed in four days, and from this time the general condition of the patient improved. At the end of a fortnight from the date of operation, my patient went to stay in the hills again, and returned to town after being away two weeks.

My final entry, written on the 18th February of this year, the day before she sailed for Tasmania, and two months after the iridectomy, is the following:—

V. { L. Sees large objects; T. normal.
R. Reads No. 1 S + 1.75 d, sees No. 4 S - .75 d; T. normal.

Ophthalmoscope.—L. The optic disc very white and deeply cupped, vessels atrophied, and the whole appearance that of atrophy of the disc. R. Cupping well marked; o. d. good colour; vessels not much altered in calibre.

Remarks.—The admirable results of the operation of iridectomy in acute glaucoma have long admitted of no doubt, tested and endorsed as they have been by most (if not all) of the distinguished oculists of Europe. To von Græfe are we indebted for the discovery of this most valuable surgical aid, and by its means hundreds of eyes have been saved. Mr. Johnson, who is a thorough believer in the efficacy of iridectomy in acute glaucoma, says:—"An iridectomy is beneficial in three ways. 1. It empties the anterior chamber, and thus relieves the pressure from both chambers. 2. By removal of a portion of engorged iris, it divides a number of vessels, and thus allows a free drain of blood from the inflamed and overloaded vessels, not only of the iris, but also of

the ciliary body and processes. . . . 3. Lastly, the section of the cornea allows a permanent drain, which relieves the pent-up lymph spaces around the angle of the anterior chamber."

Now let us look at what takes place in chronic glaucoma. To quote still from Mr. Johnson's book, he says, "Here the primary obstruction does not depend upon an acute inflammation, a vascular engorgement, or even upon a passive dilatation of the vessels, but upon slow and gradual changes in the ciliary body and the tissues around the angle of the chamber, by which the connective tissue becomes increased, and contracting, tends to narrow and imprison the lymph spaces, and to firmly tie down the iris against the contiguous cornea. This pressure sets up changes in the iris, which render it so liable to tear, so rotten and inelastic, that to remove the iris up to its root (an essential part of the operation for glaucoma) becomes an impossibility; hence the uncertain action of iridectomy in chronic glaucoma. . . ."

We must therefore look for some other operation, which will be, as Dr. Wecker says, "more simple, and essentially more logical than iridectomy." Several operations have been introduced and practiced, only to fall away into disuse, to make room for another new proceeding. I would ask, have we found this *facile princeps* in Johnson's operation of scleral paracentesis? I fear not.

The points which I would venture to criticise as objections to the operation and misleading to the operator in scleral paracentesis, as performed by Mr. Johnson, are the following:—

I. The size of the blade of knife.

II. The large wound in sclerotic.

III. Absence of anæsthetic, and no need for confinement to bed.

IV. The after treatment.

I. I think the knife, as depicted in Johnson's book, is far too large in the blade for the requirements of the operation. All we are asked to do is to make an incision into the vitreous humour, to enable the lymph to escape. In performing my second operation, about a fortnight ago, I selected a sclerotome which is not much wider than a Græfe's cataract knife, and it answered very well, as the wound healed in four days. The patient expressed himself much better, the tension was decreased from + 1 to normal, and the sight was much improved.

I would, however, suggest an improvement, namely, to have a knife made the same width as a sclerotome, but much thinner, and the edges (both sides) very sharp for half an inch from the point.

II. The large wound in the sclerotic renders the operation unnecessarily hazardous, and as in

the case of the lady whose case I have reported, took three weeks to heal, to say nothing of the loss of vitreous which occurred.

III. It requires a great amount of moral courage to submit to an operation upon an inflamed and painful organ, however trivial that operation may be, in a patient already suffering from great mental depression, which chronic glaucoma necessarily entails. The greater frequency with which this disease attacks females, and at a time of life when they are least able to fight against it, adds another reason why an anæsthetic is needed. Probably, now that we have cocaine as an addition to our anæsthetics, we shall find all that we require to stave off pain during most operations upon the external portions of the eye, in that drug. Ether, at any rate, is always available, and in the event of cocaine not succeeding, or being unobtainable, should be used whenever this operation of scleral paracentesis is to be performed. Mr. Johnson says, as one of his objections to iridectomy in chronic glaucoma, "that the patient is confined to bed for a time, with the other accompaniments of an important operation." In my case I had to keep my patient in bed for the first week after the scleral paracentesis, to avoid the risk of great loss of vitreous, owing to the gaping of the wound and the constant discharge of that fluid; whereas after I had performed iridectomy on the same patient, she left her bed on the second day.

IV. In speaking of the after treatment, Johnson says on page 42, "The speculum is then removed and the eye bandaged up with a cotton wool pad for 24 hours, or longer if necessary, until the wound has begun to heal up. Unless the vitreous be *very* fluid, a condition which is nearly always accompanied by grave structural changes in the choroid and retina, and which therefore is unfavourable to vision; the loss of vitreous need not be feared. Lymph always escapes, but the pressure being on the inside of the globe (in this case a fortunate coincidence), as soon as sufficient lymph has escaped to allow the tension to sink below normal, the natural elasticity of the walls themselves close up the wound and prevent any further loss of fluid. . . . No anæsthetic is needed, the pain of the increased tension being generally greater than that of the operation, and the relief is always immediate and generally permanent." In my first case (the one I have reported), that of a patient who had been suffering from the disease for three months previously to my operating, and whose recuperative powers were brought low, the wound did not heal for three weeks. Moreover, the vitreous escaped pretty freely, although there was no structural change in the choroid or retina, as proved by the marked

success of the iridectomy. Lymph only escaped at the time of the operation, but what filled the wound afterwards was vitreous. There is considerable difference between bandaging a patient's eye for 24 hours, and bandaging it for three weeks; and yet I was compelled to keep closely to the latter proceeding, and that after having followed every detail of Johnson's directions.

In conclusion, I would say that with some modifications, Johnson's operation of scleral paracentesis may be useful in some cases of chronic glaucoma, but I fail to see how the good is to be permanent. He mentions having performed the operation twice and even three times on the same patient, a fact which rather tends to the belief that it is not permanent in its action. I trust, however, I have given good reasons for not having submitted my patient to a repetition, but of having at once recourse to the more rational treatment of iridectomy.

TWO CASES OF ACUTE NECROSIS OF THE BONES OF THE FACE, OCCURRING IN CONNECTION WITH ACUTE INFECTIOUS DISEASES.

By JOS. C. VERCO, M.D. ET B.S., LOND.,
F.R.C.S., ENG., L.R.C.P., LOND., ADELAIDE,
S. A.

F. M. D., female, æt. 4½. She contracted the measles at Mount Pleasant, was under the care of a medical man there, and was sent down because of a sort of gumboil which had developed with much fœtor of the breath. When seen by me she seemed rather a delicate child. The measles rash had quite disappeared, the breath was very offensive, the upper lip and about the nose was very little swollen, without inflammatory redness, and a small black spot less in size than a pea existed in the upper lip close to the left ala nasi. The front incisor teeth had fallen out, and the bone could be felt bare along the alveolus. The black spot enlarged, and melting away left a hole, and this progressed steadily until the upper lip had completely disappeared, the whole of the soft parts of the nose, the left lower eyelid, and the left cheek, leaving a gigantic chasm with the necrosed bone lying bare at the bottom of it. There seemed to be scarcely any pain attending the extension, and very little constitutional disturbance. The child's mind was clear almost to the last. She gradually grew weaker and died of asthenia nine days after being first seen.

M. H., female, æt. 10, was a delicate child, had had infantile paralysis causing club foot, demanding tenotomy for its relief. Had several attacks of strumous corneitis. While under treatment for this, she contracted enteric fever on March 20,

1884. The case was a very severe one, the diarrhoea being very troublesome, although the temperatures were not persistently high. She had a loose temporary canine tooth on the left side in the lower jaw; and as this seemed to irritate her, the mother pulled it out with her fingers during the second week. She also had a pimple on the left side just above the chin, at the beginning of the third week, which she was constantly picking and which became much inflamed. On April 7 the left side of the face was somewhat swollen from an inflamed gland under the jaw—supposed to have arisen from this inflamed pimple, and a poultice was applied. Two days afterwards, as the breath was very foetid, on examining the mouth there was found a grey slough in the floor, under the tongue, and close to the alveolus of the jaw. The day following three of the teeth were discovered to be loose, then came a black spot in the cheek about an inch below and outside the angle of the mouth. In two days this was one inch by two inches in diameter, and it spread for some days. The tissues adjacent were cedematous, and immediately around the sloughing area was a narrow inflamed border. A distinct line of demarcation formed, and the slough separated of itself except that a cord-like structure, which ran nearly through the centre of the mass and supposed to be the facial artery, required division above and below.

The condition after its removal was as follows:—Speaking generally, all the left boundary of the mouth was gone. The left angle of the mouth was destroyed, so that the lips were separated; from the upper lip the wound extended up and out to the reflexion of the gum on the upper jaw, opposite the second bicuspid tooth, where a small portion of the upper jaw was necrosed, then out and somewhat downwards to the edge of the masseter muscle, then downwards to below the margin of the lower jaw, along the body of the jaw to about half an inch from the centre of the chin, and then upwards and outwards to the angle of the mouth. The tissues in their whole thickness were destroyed, and the lower jaw was necrosed and exposed in the wound. Her fever gradually subsided; she improved in condition and was able to return to the country, with the chasm in the face granulating and cicatrising all round its edge.

She came under observation again on Oct. 14th, and the next day, under ether, the necrosed parts of both jaws were removed. The exfoliation from the upper jaw was seen to consist of the alveolus containing the canine and the two temporary molars, and when removed left exposed and loose the unerupted permanent bicuspids. That from the lower jaw contained the complete sockets of

seven teeth, and the back part of the sockets of three more; it extended from the left ramus to the back of the right canine. At the mental foramen it involved not only the alveolus with its temporary and unerupted permanent teeth, but almost the whole thickness of the body, a thin shell at the lowest part alone remaining.

On Nov. 15th, about a month after, the first operation was undertaken to close in the ghastly gap in the face. Owing to the contraction of the scar the upper lip had been curled upwards and outwards beyond the ala nasi; the lower lip had been curled on itself so that the left angle was attached close to the middle of the chin; the left side of the tongue was exposed from the tip and down to the floor of the mouth; the remains of the lower jaw had cicatrised over. There was a continuous flow of saliva out of the gap down the neck, so that her dressings required to be changed as many as a score of times a day.

She was put under ether, and about half-an-inch of the adjacent edges of the two lips at the left angle were brought together. To do this, the chin had to be almost completely separated from the jaw-bone, and the cheek very freely from the upper jaw. So as to save tissue and give the greatest amount of uniting surface, a flap of mucous membrane, half-an-inch wide, was dissected up from the inner surface and margin of the lower lip, and a corresponding piece of skin and mucous membrane from the outer surface and margin of the upper lip. This was fixed inside the lower lip, and the piece from the lower lip outside the upper lip, by hair sutures, and then all kept tight with a couple of hare-lip pins.

She was fed during the process of healing entirely through the gap in the face, so that the lips were not once opened until the union was complete.

On Dec. 5th a further operation was performed to restore the cavity of the mouth. A pattern in paper was taken of the gap, and marked out on the left arm; the hinge of the flap was about two inches and a half long, and the width of the flap about two inches, and was so arranged that with the arm fixed to the head, the hinge would correspond with the margin of the body of the jaw, and the flap would be without strain, and without any bending on itself upon the cheek. The skin and its whole thickness of fat were first dissected up and left to glaze over. Then the margins of the chasm in the cheek were pared all round, and the surface of the jaw-bone where it appeared was denuded of its scar covering. The arm was now brought up and applied to the head, so that the right ear lay in the palm of the left hand, the head being turned to the right side. The arm and head were bound together by wide strips of adhesive plaster, and both of them to the body.

The flap was united along its rounded free margin to the chin, lips and cheek, and near the hinge lay upon the freshened surface of the bone. As the wound in the arm was out of sight and out of reach, it could not be dressed and had to take its chance. Speech and movement were forbidden. Injections of beef tea and laudanum were administered by the rectum—no food by the mouth. No dressing was applied to the face. Union took place by primary adhesion around almost the whole circumference of the flap. On the fifth day, as the plasters were very disagreeable with vomit and discharges from the arm, chloroform was administered, and these were changed, the hair sutures were removed, and one inch of the pedicle of the flap on each side was divided with scissors. Food was now administered by the mouth in a fluid form through a flexible catheter, and the injections were stopped. I had wished to keep the arm up for a fortnight, but after three days more the arm was getting so sore, and the neck and front of the chest so excoriated with discharges, and the child so restless and irritable, that the temperature began to rise, and against my will I had to get the child put under chloroform, and completely divide the pedicle, only eight days after the primary operation. It blanched immediately like a cadaver, and remained so for nearly twenty-four hours, but it was kept warm and moist, and gradually recovered itself, with the exception of a fine line of slough along the place where the pedicle was finally cut through. With the liberation of the arm the constitutional disturbance wholly disappeared, the flap proved to have united firmly all round its margin, and by its under surface to the denuded body of the jaw-bone, close to the hinge of the flap, so that the cavity of the mouth was completely closed and no more dribbling of saliva could occur. It was dressed with zinc ointment, and on Jan. 6th she was able to return to her home in the country.

There are several points to which I might refer in connection with this case. 1. As to the cause:—Was it necrosis of the bone, causing sloughing of the cheek, or was it sloughing of the cheek due to plugging of the facial artery, causing necrosis of the bone? If the necrosis was the first element and began in the lower jaw, why was it that a part of the upper maxilla necrosed as well, and why did the necrosis confine itself to the alveolus almost entirely, and not affect the body? May it not be that the sore on the chin inflamed the lymphatics under the jaw, caused plugging of the facial and sloughing of the cheek, and of the parts covered by it, and to some extent supplied from it—that is, the alveolus which is covered over by the vascular gum? This would explain the small necrosis of the upper maxilla, as well as the larger necrosis of the lower one.

2. In regard to the operation, we learn how vital are the tissues in children, and how readily they unite. I was two hours paring and freeing parts to get the remains of the lips together, and though one, the lower, was a mere fragment, and the tension was great, union was perfect. So again though the large skin flap, $2\frac{1}{2}$ in. by 2 in., was united only by its edges, and had nothing to rest upon but swing over the cavity of the mouth, except close to its hinge where it rested along a line of bone, it retained its vitality and united at every point where it touched.

3. As to the details of the operation:—In the text-books, when the Tagliacozzian operation is described, we are told that the flap should be cut and laid on a piece of wet lint, and allowed to thicken and granulate for a fortnight before being fixed *in situ*. But in thinking the matter over, this seemed to me utterly bad surgery, for in the first place, under such circumstances it depends for its blood supply wholly upon its pedicle, whereas if fixed at once to the margins of the freshened wound, if union occur it draws a blood supply at once from this source as well; and in the next place, after it has been left to swell and granulate for a fortnight it has to be submitted to the further manipulation necessary to denude it of granulations along every edge and every portion of its surface where it shall have to come into contact with the freshened wound—which manipulation would be more difficult and more dangerous to the flap than the original dessicative of it up. And in the third place it is evident that an extra fortnight's time is squandered. So I preferred, contrary to the rule, to attach my flap at once, and the result justified the step. Had it been possible I should have preferred to leave the pedicle a few days more before cutting.

DEPRESSED FRACTURE OF SKULL— PARALYSIS OF RIGHT SIDE— TREPHINING—RECOVERY.

By H. V. DREW, M.R.C.S.E., RESIDENT
SURGEON TIMARU HOSPITAL, NEW ZEALAND.

ALEX. D., aged 42, was admitted to this Hospital on Sunday evening, the 15th February. When seen by me a few minutes after admission he was sitting up in bed, and quite sensible. He nodded and smiled when I spoke to him, and told me that a big cart horse had reared and in coming down had struck him on the head with one of his fore feet, which stunned him for a few minutes, and when he tried to get up he found himself paralysed all down the right side.

On removing the dressing from the head, a pulsating area the size of half-a-crown was visible,

and on examination, under chloroform, which was kindly administered by a gentleman in practice here, the bone was found to be sunk right into the brain, the same having welled up over it. Not being able to remove this bone, I used a small trephine at the extreme margin of the fracture, which enabled me to remove all the fragments, also about $\frac{1}{2}$ oz. of brain matter, as near as I could judge, this being completely disorganised. All foreign matter, clots, &c., &c., having been removed, the scalp was laid down without sutures of any sort, a piece of Lister's protective covering the wound; over this a small piece of lint, wrung out in a 1 in 40 carbolic solution, and a piece of iodoform wool, to keep up soft uniform pressure. Irrigation with 1 in 40 carbolic solution (iced) was resorted to, but was soon substituted by rectified spirit lotion, as symptoms of carbolic poisoning began to manifest themselves.

On the 18th day, patient could *flex* his previously paralysed leg, on the 25th day he could *extend* the same leg, on the 27th day he began to recover the use of his arm flexion only, and on the 30th day extension of the same arm; he has no power yet to promote or supinate the hand. On the 32nd day, patient had a bilious attack, and his temperature rose to 101° , his pulse being 150, but fortunately by the use of calomel both were reduced in 48 hours to normal. Patient during this attack never vomited in the ordinary acceptance of the word, for he has the power to cause his food to regurgitate at will, and by so doing he obviated the risk which forcible vomiting might have done him. To-day is Thursday, and on Sunday next it will be 8 weeks since he was trephined, so I trust he is now out of danger. He has recovered all movements of his arm and leg, and his head is healed, though there is a pulsating area about the size of half-a-crown.

REMARKS.—The injury was seated over the ascending parietal convolution and lobule of same, as near as I could judge. The wound was practically antiseptic, though Lister's treatment could not be accurately adhered to. The wound was dressed every day, under a continuous dripping 1 in 40 carbolic, and afterwards of spirit lotion. No sutures were employed, and accurate union was effected. Temperature never rose above 99° , except during the bilious attack. The recovery of flexion of each limb *before* extension, and at about the same interval, is noteworthy, also the later recovery of the more complex movements. Slight bagging of the scalp at the back of the head, presumably due to escape of subarachnoid fluid, was noticed, but was soon completely reabsorbed. Patient's pulse has fluctuated between 50 and 90 (except during the bilious attack), and the greatest difficulty met with in conducting the case was the regulation of the bowels.

ASSOCIATION INTELLIGENCE.

NEW SOUTH WALES BRANCH.

THE ANNUAL MEETING of this Branch was held at the Royal Society's House, Elizabeth Street, Sydney, on April 24, the President, Dr. F. H. Quaife, occupied the chair, and there was a large attendance of members. Four visitors were present in the persons of Drs. Ashburton Thompson, W. F. Quaife, McLeod, and Kendall.

The Hon. Treasurer (Dr. O'Reilly) read the Balance-sheet, which showed subscriptions for the year amounting to £227 11s. 6d., and the principal item of expenditure was £101 2s. 6d. for the *British Medical Journal*, leaving a balance at the bank of £139 13s. 4d.

The Balance-sheet, after discussion, was adopted.

The PRESIDENT then read the following

ANNUAL ADDRESS.

Gentlemen,—In accordance with the usual custom, it is my duty and privilege before retiring from the chair to give a brief account of the work of the Society during the past year, and of its position compared with that of former years. In the course of the year we lost five members by resignation, one by death, and twenty-three new members were elected, leaving a total on the roll of 117 at the end of the year. At the last annual meeting Sir Alfred Roberts was elected President, and gave us the honour of his able guidance at several meetings, after which, to our great regret, the state of his health obliged him to resign. The association then did me the high honour to elect me, for which I have again to heartily thank them. Dr. Warren found it necessary early in the year to resign the Secretaryship, having filled the office for a considerable time with great ability and assiduity. In his place Dr. J. M. Creed was elected, who still holds the office. In November Dr. W. O'Reilly was elected Treasurer, in place of Dr. Brady, who had left the colony. I must congratulate the Association on the great energy of its members during the year. Valuable papers on professional subjects were read, and pathological specimens shown and explained, by Drs. Foreman, O'Connor, Fortescue, Skirving, Lovell, Creed, Warren, Bowling, Cox, C. Morgan, Muskett, Collingwood, Shewen, Hoff, Crago, and M'Donagh. The subjects of these were ably and largely discussed, some of them being of great public interest. The journal of the Australasian branches has been conducted with great ability by the editor, Dr. Creed; the standard has been fully kept up, the contents of each number being marked by great excellence, variety, and spirit. I must refer to one matter which has given the council exceeding anxiety and trouble. Owing to some misunderstanding on the part of the English office, the journal of the parent society has not been furnished to the members of this branch with the regularity that is proper. The council has done everything in its power to get the journal delivered correctly, and feels keenly the injustice done to individual members. It hopes, however, that recent

arrangements may prove satisfactory. During the year 1884 several events of the highest public importance connected with medicine occurred, important not only to this colony, but equally so to all Australasia, and I am proud to think that to our energetic and judicious health officer—Dr. Mackellar—the credit is due of suggesting that the whole of the colonies should combine to establish a federal quarantine to enable them to prevent the introduction of infectious diseases from over sea, the liability to which is increasing at a rate commensurate with the growth of commercial communication with other countries, and the rapid lessening of the time which is occupied by steamers in their passages. Through this Association the views of Dr. Mackellar were placed before the Government, and a conference of medical representatives of all the Australasian colonies was invited to be held in Sydney. The conference met in September, 1884, and was attended by representatives of all the Australasian colonies except New Zealand. After many sessions and exhaustive consideration, a large number of resolutions were drawn up and adopted for recommendation to the various Governments represented. The resolutions dealt with the subjects discussed under the undermentioned heads:—The adoption of one uniform Quarantine Act for Australasia, the provision for medical inspection of vessels, and presentation of a uniform bill of health, immigration, compulsory vaccination, notification of infectious diseases; provisions for dealing with special diseases, such as small-pox, cholera, yellow fever, typhus and relapsing fever, scarlet fever, &c., which demand somewhat different management for their exclusion; federal quarantine outposts, one for the west and one for the north approaches of Australasia. The conference expresses itself as influenced by the "determination to check disease, and to do so by measures which should obstruct commercial intercourse in the smallest degree." I think that a perusal of the report will show that the resolutions fully bear out the above spirit, and are admirably adapted to bring about the end in view. It is to be sincerely hoped that ere long the colonies will have made them law, and so laid the first stone of that greater federation of the Empire we are all so anxious to see consummated. It is pleasant to record that amidst all this grave work social duties were not forgotten, and that the medical profession entertained their brethren of the conference at dinner during the session. After the epidemic of small-pox of 1881-2, the Government made permanent provision for the management of future outbreaks in accordance with the recommendations of the Health Board, placing the existing establishment at North Head in a very efficient condition, and instituting a complete sanatorium and hospital at Little Bay. It was well that they did so, as last year, on 28th August, a fresh outbreak took place, which lasted till February of this year, the port being declared free about the middle of March. During this outbreak sixty-four people were attacked, and four died. The mortality is much less in proportion than in the former epidemic, when, out of 154 cases, there were forty deaths, of whom ten were vaccinated in early life, and twenty-nine were unvaccinated. It is interesting to note that by far the larger number of patients were unvaccinated, and of those vaccinated nearly all had been vaccinated in early life, and not re-vaccinated. In five families having a total of thirty-three members, there were twenty-three cases of small-pox, all in unvaccinated persons, the rest who escaped being all vaccinated except one. The statistics of the last epidemic are not yet available, but the figures derivable from the *ad interim* report show that nearly all the cases were either unvaccinated, doubtful, or imperfectly

vaccinated. It cannot be too deeply impressed on vaccinators that the protection is entirely proportional to the size and number and completeness of the cicatrices. It seems also demonstrated beyond a doubt that good re-vaccination is an almost perfect protection against attack, and, if not, then it is against death. I hope the Legislature will not long neglect the measures necessary for the perfect protection of the people of this country from so terrible a plague. In June last a severe outbreak of cholera asiatica occurred in Southern Europe. It began at Toulon, and then spread to Marseilles, and in less degree to several towns of France, including the capital. At Toulon the deaths reached as high as fifty per day, and the epidemic lasted till the middle of September. At Marseilles the first deaths were noted on June 27th, and in the height of the epidemic there were upwards of 80 deaths daily in the second and third weeks in July. The abatement in severity and fatality then began, but it was not till the middle of September that the disease lost its epidemic form. Other towns were attacked, and at Perpignan there was a large number of deaths. At Toulon the total number reached 900; at Marseilles over 1,700, and the deaths at other places in France in this earlier epidemic would bring the numbers up to 3,000. The greatest severity was felt in Italy, the first place effected being Spezia, where many hundreds of people died. After attacking many other places in the north, Naples was infected about the 26th August, and here the greatest virulence of all was felt. Early in September the deaths rapidly ran up, and on the ninth of that month 493 were recorded. After lasting till the third week at about this rate, the death rate fell to about 200 a day and then gradually declined with occasional rises till the end of October, since which the disease has died out. Upwards of 6,200 deaths were reported at Naples up to the third week of October. Genoa suffered severely, and over 600 deaths were there reported. Altogether the deaths in Italy nearly amounted to 10,000, according to the *Practitioner's* report from which the above figures are taken. In Spain also there was a widely diffused epidemic, but the authorities have been very reticent as to the true numbers. It seems to have centred at Alicante, on the south-eastern coast, and not to have spread far inland. In November an outbreak took place in northern France, Nantes being attacked, and soon afterwards Paris. At the former place the deaths reached nearly sixty in all, and in Paris they nearly reached one hundred a day for a short time, when there was a rapid subsidence. Altogether nine hundred fatal attacks occurred. A limited but severe outbreak took place at Yport, a Norman fishing village, which throws great light on the share which insanitary conditions of life have in perpetuating and spreading such diseases. The crew of a vessel that arrived at Cette, in the south, were attacked by cholera, and two died; of the remainder, one who had suffered reached Yport, and on the day after his arrival his clothes were wrung out of water by his relations and hung up in the street, the slop water being allowed to flow down the street. In the course of a week the sister-in-law, then suffering from diarrhoea, washed out the same garments at the public well, and on coming back she was seized with cholera and soon died. Another woman died four days after, and five others in the course of a fortnight. Yport seems from Dr. Gilbert's account to be a typical place for the spread of cholera, from the denseness of the population and the restricted area which the dwellings occupy. The principal street runs along a narrow valley, and is intersected by a series of narrow by-paths, where in low dwellings excavated in the sloping surface, and having the natural soil for a flooring, the native

fishermen and mariners live. The rooms are little better than cellars and very filthy. It was through one of these wretched lanes, that the washing water of the clothes was allowed to ooze along, the result being that the disease spread from house to house. Buildings were isolated, disinfected, and some of them appropriated as hospitals, and at last, after the middle of November, the disease was subdued. Out of forty-two cases, eighteen died. Premising that a satisfactory conclusion as to the cause and spread of the disease is more likely to be reached in a place like Yport than in such populous centres as Paris or Toulon, Dr. Gibert sums up as follows:—"That cholera was imported into Yport. That it was imported by means of soiled garments. That from the moment when these articles were washed they became the agents of rapid and serious contamination. That the cholera spread by means of contagion from house to house, and was traceable day by day, without there being a single instance that could be attributed to aerial transport of the morbid germ. That sanitary measures, although far from complete, succeeded in stamping out the disease. That the entire destruction of the discharge of cholera patients, together with the destruction or efficient disinfection of infected articles, appears capable of staying the spread of an epidemic which is as yet limited in its dimensions. That aerial diffusion appears to be an erroneous doctrine, and as to this he cites the fact that three sisters of mercy and three physicians or medical students lived for a month at Yport under circumstances most favourable to the reception of the contagion, and that it sufficed for their escape for them to take all their food at a distance from the sick, and to avoid all handling of soiled and damp garments, and the like. Finally, he explains that the question of infection by means of water does not arise, by reason of the fact that the inhabitants of Yport never drink any. It appears that Rome, during the late epidemic, escaped marvellously well, and that she did so through her having an excellent and abundant water supply, and a fairly perfect system of sewerage; while the drainage of Naples is much neglected, and the habits and dwellings of the poorer classes are filthy. What would be the position of our own metropolis in the event of any epidemic infectious disease obtaining a footing in it? Are we in such a sound sanitary condition that we may meet it without fear? I am afraid not. We have one such complaint always with us—enteric fever, dormant during winter and virulent during spring, autumn, and a little less so in summer. Its prevalence is extending year by year rapidly, and my experience leads me to think that there are more severe cases and more deaths in proportion to the total number of cases than heretofore. It is not confined to the overcrowded localities, nor to the poor, but attacks the well-to-do almost as much; though no doubt, owing to precautions taken in time by the latter class, it does not spread so much among them. Probably, only the resisting power of healthy constitutions prevents numbers more being attacked. It seems to me a disgrace to this wealthy and enlightened community that we should have so much of this disease among us. Are we doing anything to spread it, or to combat it? I think we are doing quite as much to spread it as the reverse. We allow houses, terrace after terrace, to be built without regard to healthy conditions of size, ventilation, or drainage. There is at present no authority to insist on such being carried out. That terrible invention, the cesspool, is used in thousands of instances all round the suburbs and in many parts of the city, polluting the air with its fumes and the soil by its overflow in many cases, and by soakage in nearly every case. In those parts of the

city where there is sewerage, dozens—not say hundreds, or even thousands—of premises are connected in such a way that "they have," as Teale says, "their sewer gas laid on like their water and their coal gas," and as far as I know there is no power to rectify such things; at all events they are not rectified. I know of one large new terrace in a high and healthy part of the city that has its waterclosets, internal ones, connected in the most exploded fashion with the sewer, without any ventilation whatever; in the older ones that appears to be the rule. May I impress on you, gentlemen, and through you I hope on the public, that a first-class water-trap, unventilated, transmits sewer gas containing possibly infecting particles in less than an hour and a half. There is yet no means of preventing building upon low lands very difficult to drain, some of which reek with the filth of poison, the accumulation through many years. In some such places, which I could more definitely mention, there are dairies which supply a large quantity of milk which must become speedily contaminated. Anyone who will visit the suburb of Waverley may note that south and west of the tram-line, with an insignificant exception, the land slopes with a considerable grade towards the head sources of our water supply. The whole of the drainage is surface drainage, and a large part of the excreta is deposited in cesspools. Some of the street gutters drain directly into the swamps, and in wet weather the whole of the stagnant filth which accumulates in dry weather is poured into the metropolitan watershed. Filtration dams have been erected and no doubt stop coarse matters, but they cannot stop germs. I wonder that we are as free from disease as we are. On the slopes described there must be now built from fifty to one hundred dwellings, and for some time to come they must discharge their drainage as stated. Enteric fever arises wherever masses of human beings congregate, unless special measures are taken to prevent it. That is proved by the fact that there have been severe outbreaks at the Prospect dam, the Great Northern Railway, and the Bondi Sewer Works. The last has been very extensive. There have been very severe cases, and several deaths. Nearly the whole infection of this complaint is contained in the excreta, and in dealing with these lies our only hope of extirpating the disease. It cannot be too much insisted on that they should be destroyed by strong disinfectants, and then buried in dry soil, or better burnt: the latter, however, is mostly somewhat impracticable. I have given you a somewhat gloomy view of our position; but there is a brighter side. We are assured that within some months we shall obtain from the new Nepean works sufficient water to guard against want, and in a longer, but, I hope, not very far off time a full supply for all needs. I trust the authorities will urge on the works with all the speed possible, with due security for the soundness of the works. We are also cheered in knowing that the new sewerage works for the southern part of the metropolis are on the eve of completion, and that those on the northern side are progressing rapidly. I hope that a competent board, composed of scientific men and full of energy, and provided with full powers to carry out the outcome of their decisions, will be appointed to take charge of these two great divisions of our sanitary armament. For, gentlemen, preventive medicine is the medicine of the future, and, as the late Lord Beaconsfield said, the most of that is sanitation. When I look along the list of distinguished men in all enlightened countries, members of our profession, who are at work in this department, I am proud to feel assured that we in this colony, which has in many other ways lately advanced so much, will be emulous of our brethren

in the older worlds, and be ever in the war with ignorance, selfishness, misery, and disease, in their traditional place—the fore-front of the battle.

A unanimous vote of thanks was accorded to the President for his address, on the motion of Dr. Craig-Dixon, seconded by Dr. Rowling.

ELECTION OF OFFICERS.

The following were the officers elected for the year:—President, Dr. O'Reilly (Dr. MacLaurin having declined the honour); vice-president, Dr. Knaggs; hon. treasurer, Dr. Rowling; hon. secretary, Dr. Creed; and auditors, Drs. Craig-Dixon and Pickburn. The council for the year will consist of Drs. Knaggs, MacLaurin, Creed, Macellar, O'Reilly, Quaife, Rowling, Tarrant, and W. E. Warren.

This concluded the business of the evening, and a vote of thanks having been tendered to the retiring President, the meeting terminated.

SOUTH AUSTRALIAN BRANCH.

MONTHLY MEETING.

Held at the Adelaide Hospital on Thursday, March 26th 1885; the president, Dr. C. Gosse, in the chair. Prof. Watson was present as a visitor.

W. T. Hayward, Esq., read the notes of a case of Carcinoma of the Uterus, in which the organ had been removed *per vaginam*, by Dr. Gardner (*vide p. 185*).

Dr. GORGER remarked that, as the extirpation of the carcinomatous uterus had been discussed so often during the last few years, he had not thought it worth while to bring before the meeting two cases he had operated upon; but, as Mr. Hayward asked for a discussion, he would like to mention them briefly. The first case was one of partial removal, and was performed by him about six years ago. The patient, aged 45, was suffering from carcinoma of the portio-vaginalis uteri, with frequent hæmorrhages. The diseased portions were all removed by a funnel-shaped incision high up in the corpus uteri, and a tampon with liq. ferri mur. was applied. In the night following the operation he was sent for, as there was profuse hæmorrhage from the wound, which, however, was speedily arrested. The patient was discharged recovered in the course of a few weeks, and has remained well and healthy up to the present date.

He removed the entire uterus of another patient on December 23 last, with the able assistance of Drs. Ellison, Henderson and Jay. The patient, aged 59, had complained of pain over the stomach, dyspepsia, and other pains here and there. She was very pale, and suffering from general ill-health, slightly feverish, and presented all the appearance of having recently lost flesh. She was treated at first symptomatically, under the idea that there might be cancer of the stomach. A few days afterwards, upon being informed of the existence of a constant vaginal discharge for the last three years, he insisted upon an examination, and found a very copious purulent discharge from the vagina, caused by carcinoma of the portio vaginalis and corpus uteri. The body of the uterus was moveable all round, and only showed signs of adhesions upwards; also the anterior lip of the vaginal portion was adherent to the anterior wall of the vagina by carcinomatous adhesions. The patient was informed that total extirpation of the uterus was the only means of giving her any possible chance of eventual recovery, although, considering her age (59) the prognosis was extremely unfavourable. After a few days consideration and consultation with her family, she decided upon undergoing the operation.

Having fixed the os uteri with two bullet forceps, he cut round the vaginal portion, and passed up the finger to fix the body of the uterus from behind, working towards the bladder. Having succeeded to a large extent, his finger passed into an abscess cavity, which communicated with the interior of the uterus through a perforation in its carcinomatous fundus. About two ounces of pus escaped. To get more room, the parametrium was ligatured on both sides and cut through, and he was thus enabled to apply more tension to the carcinomatous adhesions binding the anterior lip of the os uteri to the posterior wall of the bladder. Having debated whether to open into the bladder and remove the affected part at once, or to leave it at present, with a view to operation measures at a subsequent date, should the first operation prove a success, he decided upon the latter course as the best for the patient, and as avoiding the risk of urine draining into the abdominal cavity with a fatal result. The uterus was removed, and the parts washed out with a solution of perchloride of mercury. A plug of iodoform gauze was introduced, and a pad of salicylic wool applied. The patient was kept in a half-sitting position to facilitate the escape of any discharge. During the afternoon the patient vomited several times. The following day (24th) the temperature was 98.5 in the morning, 100.0 at night; very faint and low.

December 25—temp. 100.4; fairly comfortable all day; had had a bad night; bowels open three times; very little discharge; had vomited once.

December 26—temperature normal; constant diarrhoea.

December 27—very restless; mind wandering; plug removed, very little discharge; wound looking very well; urine clear.

December 28—profuse perspiration; vomiting.

December 29—drowsy; diarrhoea stopped; passes urine unconsciously.

December 30—temperature normal; cramp in the stomach; vomiting; evidently sinking; died at 1 a.m. on the 31st.

A post-mortem examination was refused.

After reading the different journals, and seeing the reports of the various writers, he had found it very difficult to arrive at any conclusion as to which operation was the best one, either as a general rule or in particular cases. The very instructive report of Hofmeyer (Berlin) zur Statistik des Gebärmutters-Krebses und seiner operativen Behandlung, which is based on the cases of the Berlin gynaecological clinic, under Prof. Schroeder and his private patients during the last six years, gave, in his opinion, some data to go upon as regards results. The report includes a record of 16,800 patients from the clinic, and 9,400 from private practice, making a total of 26,200 cases. Of the former, 603 suffered from carcinoma of the uterus; of the latter, 209; or 3.6 per cent. in one set, and 2.18 per cent. in the other, thus showing the greater prevalence of carcinoma of the uterus amongst the working classes.

The disease originated in—

Portio vaginalis	in 236 cases
Cervix uteri	in 181 "
Corpus uteri	in 28 "
Uncertain	in 367 "

According to this the corpus uteri was affected in only 3.4 per cent., and of these 21 per cent. had not borne any children.

The average age of the patients, and the part affected, was as follows:—

Portio vaginalis	aged 42 years.
Cervix uteri	" 47 "
Corpus uteri	" 54.5 "

Of the whole number of cases upon which the observations were made, 160, or 19 per cent., of them were operated upon with a view to a radical cure. The rule laid down for the operation was—for carcinoma of the portio vaginalis uteri, vaginal or supra vaginal amputation per vaginam; for carcinoma of the cervix uteri, the total extirpation per vaginam, according to Freund's method in his earlier practice, later on, however, adopting Zerny's method; and for carcinoma of the corpus uteri, abdominal supravaginal amputation.

Of the patients operated upon, 19 per cent. died, namely:—

- Of 105 amputations 13, or 12.3 per cent.
- „ 8 Freund's operation 5, or 62 per cent.
- „ 34 total extirpation per vaginam 9, or 26 per cent.
- „ 13 abdominal supravaginal amputation 4, or 30 per cent.

There seems to be a prospect of the results of operating for total extirpation per vaginam being far more favourable when the modification of sewing up the peritoneum and vagina is more generally adopted, for of 16 patients operated upon by Stände, of Hamburg, there was no death.

It is important to note, as regards the permanent effect of the operations, that the results were calculated from cases that had been operated upon two or more years previously, and the recovery rate then was:—

After abdominal supravaginal amputation	80 per cent.
After total extirpation, per vaginam	35 „
„ Freund's operation	33 „
„ Vaginal and supravaginal amputation	32 „
After amputation and application of the actual cautery	42 „

In an appendix, Hofmeyer, in referring to the different methods of operating, especially points out the good results of applying the actual cautery after amputations per vaginam.

Dr. VERCO referred to a patient who had consulted him for troublesome floodings after a recent confinement. Upon examination, found a cauliflower excrescence on the cervix. This was removed with an ecraseur, and the wound completely healed for eight months. Was consulted again as the disease had again broken out, involving the uterus. The whole organ, being moveable, was removed, but the patient died of peritonitis. It was a matter for consideration whether the entire removal of the uterus and its appendages in the first instance would have prevented the recurrence of the disease. The removal by the ecraseur had at least allowed the woman eight months of life, whereas the operation for extirpation had terminated it within a few days.

Dr. LONDON asked whether, in Dr. Haywards' case, it would have been possible to remove all the malignant growth by supravaginal amputation of the cervix. (No.) He gathered from the recent discussion at the Obstetrical Society that it was the opinion of London gynaecologists that extirpation (Schroeder's operation) should only be performed in cases where the malignant disease was limited to the body of the uterus and the cervical mucous membrane, and that it was contra-indicated if the portio vaginalis were involved, or if adhesions existed, because that the mortality from extirpation was four times as great as that after amputation of cervix, and the results as regards recurrence much the same.

Mr. HAYWARD, in reply, said that complete extirpation was necessary, because part of the vagina was affected in addition to the cervix. The uterus was moveable. If the organ were fixed, that would be such

presumptive evidence of there being cancer elsewhere, as to make the chances of a successful operation very unlikely.

CHARLES GOSSE, M.D., then read notes of a case of Gliucoma, which will be found on page 187.

Dr. VERCO read notes of a case of Acute Necrosis occurring in connection with acute infectious disease, which we publish on page 189.

PATHOLOGICAL SPECIMENS.—Dr. Poulton showed prepared specimens of sarcoma involving bone from a female aged 40. Dr. Stirling had removed her left mamma, with a sarcomatous mass, in December, 1882, and also enlarged glands from the axilla at the same time. Subsequently fresh malignant growths in the neighbourhood of the mammary cicatrix were removed. She remained free from trouble for many months, and there was no further development of a sarcomatous nature in the breast or axilla; but in July, 1884, she was again admitted suffering from some swelling in the upper part of the sternum, which was the seat of acute pain, and also from an irregular hard tumour involving the upper fourth of the left thigh, which was everted and showed shortening to the extent of 3½ inches. Death took place on February 19, 1885. The femur shown had a large bony growth entirely surrounding the trochanters, and depending down over the upper fourth of the shaft. It had evidently been fractured below the trochanters. The new bone was irregular in outline and excavated in part. The shaft in two places presented erosions exposing the medullary cavity. The sternum did not show any new bony growth, but was extensively honeycombed throughout its whole length.

Also, a foetal monster with imperfect facial development, and a large cephalic tumour.

VICTORIAN BRANCH.

ORDINARY MONTHLY MEETING.

MELBOURNE, APRIL 22, 1885.

The President, Mr. Rudall, in the chair.

CASE OF STILL-BIRTH.

DR. NEILD related a case of still-birth, which possessed exceptional interest. A woman, living in one of the suburbs of Melbourne, had engaged a medical man in the neighbourhood to attend her, but delivery took place before his arrival, and the child, a female, was dead. He therefore refused to certify that it was still-born, and, in consequence, an inquest was held, the post-mortem examination of the child having been made by Dr. Neild. He found that it was mature, larger than the average, and, in all particulars, well developed. The funis was properly divided and tied, and there were no indications of violence. Internally, the caput succedaneum was considerable, and there was extreme hyperæmia of the encephalon. The docimasia pulmonum showed complete non-buoyancy of the lung, and all the other indications were confirmatory of the foetal character of the organs. The special interest of the case was represented by there being distinct evidences of apnoea. The lungs, the heart and the thymus gland were profusely marked with petechial ecchymoses, and the mucous membrane of the larynx and trachea was injected in striae and maculae, the colour being a bright pink. The lungs, although presenting the firm consistency of the foetal condition, were hyperæmatous. It was a case of intra-uterine apnoea, occasioned by pressure, somehow produced, upon the funis, and the question of practical interest was, had such pressure been made designedly? In the absence of any evidence on this point, the verdict of the jury could not be other

than that the child was still-born. Dr. Neild, however, had thought it well to record the case, in order to propound the question of how far the operation of the law extended with regard to the criminality of persons who procured the death of a child in utero? So far as he had been able to ascertain, the law took no cognisance of such an offence. The procuring of abortion was a crime, but abortion was a process having reference to the hastening of the delivery of the mother, the death of the child being only a coincidence. And with respect to infanticide, the law insisted that the child must first possess post-partum life before it could die, such life meaning respiration. He had been informed that, some years previously, an irregular practitioner in Richmond (Victoria) had announced somewhat obscenely, by advertisement in the newspapers, that he was prepared to attend pregnant women and deliver them of dead children. This announcement had attracted the attention of the police and the law authorities, the latter of whom had given it as their opinion that such practice was not illegal. Dr. Neild had been informed by a medical man in extensive midwifery practice, that the excessive use of ergot had had, in his experience, a tendency to kill the child, obviously by intensifying uterine pressure upon the funis and placenta, so as to interrupt the circulation and cause death. He (Dr. Neild) thought it possible that ergot was used by some midwives for this purpose. It was known that they were in the habit of buying it in considerable quantities from the pharmaceutical chemists.

In the discussion which followed, it was unanimously agreed that it was desirable there should be some alteration in the law with a view to the recognition of the offence of intra uterine fœticide.

EXOSTOSIS OF INFERIOR MAXILLA.

DR. NEILD exhibited the inferior maxilla of a man who had died while a patient in the Kew Lunatic Asylum, and concerning whom, during his life, there had been considerable difference of opinion as to the existence of an alleged injury of which he had complained. He had brought a charge against the attendants of having knocked him down and kicked him, whereby he said his jaw had been fractured and his shoulder dislocated. There was found, upon examination at the time, to be no injury to the shoulder, and there was declared by the medical attendants of the asylum—the late Dr. Alexander Robertson being at that time the superintendent—to be no fracture of the jawbone. As the man had always been a troublesome patient, and, before coming into the asylum, had been somewhat of a political celebrity, the matter came to be talked about publicly, and at last the subject was introduced into the Legislative Assembly, and much indignation expressed at the “brutality” to which the man was said to have been subjected. The government of the day, therefore, instructed several surgeons outside the asylum, to examine the man, and most of them diagnosed fracture, and stated, further, that it had been inflicted while in the asylum. Only one of these gentlemen was understood to have expressed any doubt of there having been fracture. Some months after this opinion was given the man died, and the usual autopsy was made on April 15, 1876. There was found to be advanced organic cerebral disease, but the immediate cause of death was cardiac hypertrophy, with an unusually large quantity of fluid in the cavity of the pericardium and thickening to the extent of a third of an inch of that organ. The lower jawbone presented the following appearances: There was no evidence whatever of fracture. On the

outer side of the left ascending ramus there were attached two spiculæ of bone, the larger being $1\frac{1}{2}$ inch long, and sharply pointed, its diameter being at the thickest portion about $\frac{1}{2}$ of an inch; the smaller 1 inch long and pointed, but not so thick. The first of these was firmly jointed to the ramus, the other was attached only by periosteum. The smaller one was a little lower down than the larger. They were both in a line with the fibres of the masseter muscle. The bone tissue in the neighbourhood of these growths was very vascular, and the periosteum was firmly adherent to the bone. There was no indication of any previous injury to the soft parts of the jaw.

In the discussion which took place—

The PRESIDENT thought it probable, judging by the direction taken by these growths, that they had originated in the masseter muscle. He mentioned a case of rudimentary cervical rib which simulated exostosis at the root of the neck. He thought the case described by Dr. Neild a very instructive one, as enforcing the necessity of being guarded in giving an opinion in alleged fractures of this bone.

CERTIFICATES OF INSANITY.

The hon. secretary drew the attention of the meeting to a recent case of murder and suicide, which illustrated the occasional difficulty of procuring, on emergency, certificates of insanity. The risks to which medical men were subjected in giving these certificates had naturally made them cautious in doing so, and it was unfortunate that, for lack of the necessary authority to remove an insane person to an asylum, disastrous results followed. After some conversation it was resolved, “That the present state of the law relating to certificates of lunacy is defective, and needs alteration, inasmuch as the effect is to deter medical practitioners from incurring the responsibility of signing such certificates under any circumstances.”

COMMITTAL OF INSANE PERSONS.

The hon. secretary also called the attention of the meeting to the practice in the police-courts of committing to prison persons brought before the magistrates “charged” with lunacy. After some conversation the following resolution was agreed to, “That the practice of committing alleged lunatics to gaol for medical inquiry, instead of sending them to some properly appointed place of reception, in the nature of a hospital, is both unscientific and inhumane.”

EXHIBITS.

The following pharmaceutical preparations forwarded by Messrs. Francis & Co., were laid on the table:

HYDROBROMATE OF CONIA. Dose, $\frac{1}{2}$ to $1\frac{1}{2}$ grains.

“Acts chiefly as a direct sedative to the respiratory centre. It is employed with advantage in all spasmodic affections, especially those of the respiratory organs.”—*Practitioner*.

“Physiological action similar to curara.”—*Lancet*.

Useful in neurosis and spasmodic affections of chronic bronchitis.

HYDRARGYRI TANNAS. Gr. $1\frac{1}{2}$ in pill.

A new remedy for syphilis, introduced by Dr. Lustgartner, of Vienna.

“The results obtained in various stages of syphilis have been so successful as to safely place it by the side of the best mercurials, without the disagreeable symptoms so generally experienced. Its introduction into the system is so rapid that mercury has been found in the urine 24 hours after using.

Also a number of other preparations.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, MAY 15, 1885.

EDITORIALS.

THE FACULTY OF MEDICINE AT THE MELBOURNE UNIVERSITY.

At a meeting of the Council of the Melbourne University held on April 21st, a number of questions of very serious moment to the Medical Faculty of that institution were discussed. The first was relative to the appointment of clinical lecturers at the Melbourne Hospital. This matter had been referred to the Medical Faculty, who reported that in their opinion it was very inadvisable that members of the medical staff of that institution should be *ex-officio* clinical lecturers of the University, but recommended that the Council should specially appoint one or two members of the staff of the hospital as clinical lecturers in medicine, and the same number in surgery. The report points out the reasonable fear that medical men elected by the subscribers to a hospital, who would hardly have the necessary knowledge to decide on the attainments of the candidates, might be very unsuitable men to act as teachers for students of the University. This is no doubt true, but still it may be said that if only a portion of the honorary staff of the hospital are appointed lecturers, it limits the number of cases from which useful knowledge might be imparted, for it would be impracticable, or at least impolitic, for the lecturer to lecture on cases under the care of his colleagues. We think the case would be best met by the election of the honorary medical staff by the committee of the hospital and the council of the University in combined conclave. Such a body would of necessity have the interests of both institutions at heart, and would possess the technical knowledge required.

The next business was a letter from a number of the fifth year students in medicine, complaining that the questions in the paper for the written examination were so vaguely worded as to render it difficult, if not impossible, for the candidates to decide as to what was required by the examiners, that in consequence of this they were so much delayed in their work, that other questions which they could understand were left unanswered from

lack of time, the result being that nine out of the ten candidates were rejected. This last fact alone is sufficient to excite some surprise, for students who have been successful in so many former examinations are hardly likely to be plucked in this wholesale manner from sheer ignorance, depending either on stupidity or idleness. That our readers may have the opportunity of judging for themselves as to the merit of these questions, we now republish them:—

- “1. Give the main relations between diseases of the lungs and heart.
2. What are the causes and phenomena of vomiting?
3. What are the principal forms of metallic poisoning? Prescribe fully.
4. Give the causes, variety, and treatment of eczema.
5. Describe fully the cardiac complications commonly met with in acute rheumatism. Prescribe fully.
6. What are the causes, symptoms, and treatment of abdominal aortic pulsation?”

Another incident specially concerning the medical faculty which came forward at this meeting was the reception of a letter from a fourth year student, who complained that he had been rejected at the examination for that year in consequence of the whole of his marks having been cancelled in consequence of his defective spelling in the paper for medicine. This letter raises a very nice question as to whether spelling should have anything to do with the result of an examination on any technical subject, always supposing it was so sufficiently phonetic as to convey correctly the meaning of the candidate? There can be no doubt that a man who cannot spell fairly is utterly unfit for admission as a medical graduate of a University, but we think this question as to the primary education of students, is supposed, and ought to be, settled at the matriculation examination in arts, which all have to pass, and that if through the laches of the examiners at this ordeal a grossly bad speller gets through, it is not a matter to be again decided at an examination on a technical subject.

Another matter of great moment to the University, but whether specially concerning the faculty of arts or medicine information is not supplied, is that some candidates have been able to obtain early information as to the result of their examination before the general declaration. If this is a fact, it reveals a gross breach of trust, and great unworthiness on the part of the examiner who disclosed it, and we most emphatically condemn his conduct.

We think the foregoing catalogue of incidents goes to show that the Melbourne University is not perfect in its government, and that it behoves all persons interested to exert themselves to the uttermost to make a satisfactory change in these, and no doubt other matters which require amendment.

PROPOSED LEGISLATION WITH REGARD TO CHARITABLE INSTITUTIONS IN NEW ZEALAND.

THE N. Z. Colonial Secretary, Hon. P. Buckley, is reported to be preparing a Bill to deal with hospitals and charitable aid matters, and to be taking Home and Canadian methods as a basis. As many of the English hospitals derive their chief revenues from the improved value of former endowments in land, we presume that the Canadian experience will assimilate more nearly with the present requirements of New Zealand. We therefore extract from Dr. Grabham's report for 1883, what he, as Inspector, drew the Government's attention to:—

The following extracts from the report of the Inspector of Public Charities for the Province of Ontario (1880) seem to be so applicable to the hospitals of this colony, that I make no apology for transcribing them *verbatim*:—

Province of Ontario.—"Coming now to the last branch of work, namely, hospitals for the treatment of bodily diseases, refuges for the poor, orphanages, &c., only within the last seven years has this class of institutions been subject to Government supervision and instruction. Before that time, the Legislature annually voted funds in aid of their maintenance, but exercised little or no supervision over the administration of their affairs, leaving that in the hands of local boards of management. The Parliamentary grants in aid of these charities were not then based either upon the work performed or upon the number of inmates in the respective institutions, but an arbitrary sum was voted to each. Moreover, many of the structures used were quite unfitted for the purposes of the charities, and in some instances the administration of affairs was of the most lax character, and no proper or uniform method of obtaining tabulated statistical information was employed. To overcome these defects, an Act (the Charity Aid Act) was passed in 1874, to regulate the public aid to hospitals and charitable institutions, and to provide for their Governmental supervision and inspection. Under the provisions of this Act, a certain fixed sum per day is paid by the province for the maintenance of each patient or person admitted; and, in order to stimulate and encourage private and municipal subscriptions to these charities, the province gives, in addition to this fixed allowance, a further sum per day for each inmate, equal in the aggregate to one-fourth of the money received from all other sources than provincial aid. The workings of this Charity Aid Act have produced the most satisfactory results. New and well-arranged hospitals have been erected, and old ones re-constructed; private subscriptions have been largely augmented; and greatly increased efficiency in management has been obtained in nearly every institution subject to the provisions of the Act.

Inspection.—"Another point of almost equal importance relates to the supervision and inspection of the public institutions. Direct and sufficient authority is vested in the Government Inspector to deal promptly with all defects, irregularities, and troubles as they arise, no matter whether the defects are of a structural, administrative, or disciplinary character. Other methods of inspection may be equally, and perhaps more, effective; but unless inspectors, commissioners, boards of directors, or other officials or bodies of a like

character, are, in addition to their inspectoral and recommendatory powers, clothed with sufficient executive authority to remedy defects and supply deficiencies, it appears to me that the prime requisite of a system is wanting."

I have not been able to ascertain the exact population of the Province of Ontario, but I have reason to believe that it was in 1880 very considerably in excess of that of New Zealand at the present time. If this be the case, it will be instructive to compare the number of hospital patients in each of these countries:—Ontario: 5,302 in-patients, 9,540 out-patients; total, 14,842. New Zealand: 6,110 in-patients, 8,985 out-patients; total, 15,095. The total amount paid in aid of hospitals by the Province of Ontario was £9,963.

The appended tables give particulars of the receipts and expenditure, and also of the admissions, discharges and deaths during the year 1882. It will be seen that 522 of the in-patients died, the death rate being about 8.5 per cent. of the total number treated. At the close of the year the number of beds occupied was 621, or 7 more than at its commencement.

The pressure upon the limited accommodation has, in some districts, been great, and enlargements and additions are contemplated or in process of being carried out.

GEORGE WALLINGTON GRABHAM,
M.D., Lond., M.R.C.P., M.R.C.S., &c.,
Inspector of Hospitals.

Wellington, 7th June, 1883.

Matters could hardly be worse than they have been, and the profession, as well as the country, will have reason to applaud any movement by the Stout-Vogel ministry to amend them.

Not only has mismanagement and the want of a system caused the Ontario cost of £10,000 to be multiplied by 5 for New Zealand, but there has been an unfair constant drain on the resources of a limited section of the charitably disposed.

The reins of power have also in many cases fallen into the hands of immoral, ignorant or disreputable people.

We speak advisedly when we say that whilst in one place a reformed drunkard may be the shining light of the committee, in many others drunkards who are not reformed figure on the board of mismanagement.

We have a New Zealand paper before us in which a medical man takes exception to his committeemen appearing at their duties in an inebriated condition and ornamented with contused optics; and from another source we hear of a noisy, abusive, and therefore a leading member, whose livelihood is gained in a manner too discreditable to be particularised in our columns.

It has also been in many smaller places no matter of difficulty for low class publicans to get on the committee and utilise the hospital for shunting their half dying, half mad customers after they had been cleaned out of their earnings.

Under all or any of these circumstances, what has been the position of the hospital surgeon? We draw the veil and leave our readers to imagine, and not to wonder when we say that instances of

the grossest injustice, petty tyranny, and ill-treatment towards them have attracted our notice from time to time.

In their crusade towards cleansing this modern "Augean Stable," the Hon. Mr. Buckley and his colleagues will have our sincerest sympathy, and we feel certain that all the moral support in the power of the press or the medical profession will be accorded them in their difficult task of amending matters, to which there is sure to be a strong opposition from interests vested or acquired.

We feel that we may fairly congratulate the profession in Australasia, as well as ourselves, on the very remarkable success which has attended the *Australasian Medical Gazette* since its establishment three and a half years since. Not only do the papers published in it excite such attention in other parts of the world, that we never receive a mail without getting some Medical Journals containing papers reprinted from it in them, but our subscribers' list includes gentlemen residing in the United Kingdom, Germany, France, Switzerland, Russia, the United States, Canada, Mexico, Chili, Peru, Japan, and China, in addition to which we regularly exchange with the medical journals in all parts of the world, and forward the *Gazette* to learned societies in the leading countries. Our subscribers in Australasia are very numerous, and are found in every colony, and almost every town.

THE MONTH.

NEW SOUTH WALES.

At a special meeting of the Senate of the Sydney University, held on April 20, a letter was received from the lecturer in pathology, in reference to the duties of his office, and urging that the lecturer in pathology should be curator of the Pathological Museum, and pathologist to some recognised hospital or hospitals; the letter was referred to the Faculty of Medicine for consideration and report.

At the Royal Society's Rooms, on April 20, an influential meeting of Edinburgh University past students took place, with the object of aiding a scheme for the formation of a Student's Union in connection with the University named. Amongst the speakers were the Rev. Principal Dr. Kinross; Professor Anderson Stuart, M.D.; Dr. MacLaurin, Rev. Mr. Jarvie, Rev. J. M. Ross, M.A.; Dr. Arthur Renwick, Dr. Skirving, Rev. Mr. McPherson, and others. A representative committee of medical gentlemen and others was appointed to carry into effect the object in view; and it was unanimously left to Professor Dr. Anderson Stuart to convene a future meeting. In the course of discussion it was particularly urged that the movement be made one of an essentially Australasian character.

At Prince Alfred Hospital, Sydney, on April 24, the Hon. James White, M.L.C., presented to the institution a complete and very valuable cabinet of surgical in-

struments, a collection containing the latest and most carefully finished implements, valued at £1000. The medical staff of the institution have long felt the want of such an outfit for operating purposes, and Dr. Fortescue, on behalf of the medical staff, thanked Mr. White for his welcome and appropriate gift. For some time they had to depend upon a miscellaneous and scratch collection of instruments, brought together by different surgeons, and they were delighted to receive the gift which Mr. White had made to the institution. Dr. Fortescue spoke in terms of high praise of the excellence and completeness of the collection of instruments, and said that the medical staff would always regard the donor with feelings of gratitude. He hoped that the Government would complete the design of this hospital, and make it one of the completest, as it was one of the noblest institutions of the kind in the world.

At the last monthly meeting of the Senate of the Sydney University, held on May 6, a letter was received from the St. Vincent's Hospital in reply to a communication from the Senate asking to be supplied with a copy of the rules of the hospital, of the appointment of its medical staff, and its regulations with regard to the teaching given in the hospital. The reply stated that the authorities of the hospital had no printed rules or regulations, but that they were willing to conform to any rules which the Senate might make for the recognition of hospitals. The letter was referred to the Faculty of Medicine for consideration and report.

A NEW wing has just been added to the Newcastle Hospital; the new building gives the hospital an air of completeness and handsome uniformity.

DIPHTHERIA is prevalent in the Quirindi district, and several deaths have occurred from that cause.

AN epidemic of scarlatina has appeared in the outlying districts of Gulgong.

DR. G. P. BALDWIN has commenced practice at Liverpool, on George's River, 22 miles S. of Sydney.

DR. C. H. S. HOZIER, late of Gundagai, has succeeded to the practice of Dr. B. J. Newmarch, of Windsor.

DR. C. MCKAY, of Rooty Hill, and late of Church Hill, Sydney, has resumed practice in the city at Belmont House, corner of York and Margaret streets, Wynyard square.

DR. L. D. PARRY, of Temora, has removed to Emma-ville, the centre of a rich tin-mining district, 425 miles N. of Sydney.

DR. B. T. RUSSELL, of Maitland, has removed to Merriwa, a thriving township in a pastoral and agricultural district, 198 miles N. of Sydney.

DR. E. R. SMITH, late of Carcoar, has commenced practice at Cowra, on the Lachlan river, in an agricultural and pastoral district, 200 miles W. of Sydney.

DR. R. C. THORP, late surgeon-major in the Indian medical service, and Dr. C. G. Thorp, late of Pictou, have commenced practice at "Rathgael House," Croydon-road and Bay-street, Ashfield, a favourite suburb, 5 miles from Sydney.

DR. G. P. M. WOODWARD, of Darlinghurst, has removed to 167 Macquarie-street, Sydney.

NEW ZEALAND.

AN action brought against Dr. Bond, of the Auckland Hospital, for £500 damages for alleged malpractice, was concluded on April 17th, when the jury gave a verdict for the defendant.

DR. E. A. BEWES, late of Ladbroke-grove, Notting-hill, London, has commenced practice at Otahuhu, a pleasantly situated township 9 miles S.E. of Auckland.

DR. J. A. LANGDON, late of Helensville, has removed to Whangarei, in an agricultural and coal-mining district, 80 miles N. of Auckland.

DR. E. D. MACKELLAR, who was house-surgeon to the Auckland district hospital in 1883, was, on April 13, appointed by the hospital committee to the honorary visiting medical staff of the institution.

QUEENSLAND.

THE new hospital at Normanton, near the Gulf of Carpentaria, is now completed and in working order. Dr. T. S. Dyson has been appointed medical officer at a salary of £350 a year.

DR. THOMAS SILVESTER GELL, M.B. et Ch. M., 1866, M.D., 1870, Edin.; M.R.C.S., Eng., et L.S.A., Lond., 1866, medical officer to the Hodgkinson gold-fields district hospital, died at Thornborough in January last. The deceased gentleman was formerly a member of the General Council of the Edinburgh University, also medical officer to the North Kensington and Kensal-town Providential Dispensary.

MR. GEORGE ROBERT LLOYD, L. et L. Mid., R.C.P. et R.C.S., Edin., 1862, travelling medical referee to the Colonial Mutual Insurance Society, died at Normanton on January 5, aged 45 years.

DR. ALEX. NICOLL has settled at Tambo, on a branch of the Barcoo river, in a pastoral district 550 miles N.W. of Brisbane.

DR. K. L. O'DOHERTY, M.L.C., of Brisbane, has left for Ireland on a visit.

DR. S. CANDIOTTIS, of Clermont, requests us to state that he has not removed to Rockhampton, as mentioned in our last issue, but that he is still practising at Clermont as hitherto.

SOUTH AUSTRALIA.

THE Board of Management of the Adelaide Hospital have, in order to meet the wishes of the council of the University of Adelaide in the commencement of a medical school, with the assistance of the honorary medical staff, prepared a new set of rules and regulations for the admission of medical pupils to the practice of the hospital. The rules have, since their adoption, been forwarded to the council, and the Board hopes that the advantages now offered for a thorough clinical education, may be largely availed of by the youth of the colony, special provision having been made that the rules shall not only apply to those connected with the University, but to students generally.

DR. GEO. CUSCADEN, late of Dominica, Leeward Islands, has commenced practice at Port Wakefield, on the shores of St. Vincent Gulf, in an agricultural and grazing district, 60 miles N. of Adelaide.

DR. E. C. HADEN, of Port Wakefield, has removed to Kingston, on the shores of Lacepede Bay, 169 miles S.E. of Adelaide.

DR. B. FOULTON, junior house-surgeon to the Adelaide hospital, has tendered his resignation, assigning no reason for his action. The committee did not accept the resignation, but appointed a sub-committee to enquire into the matter.

DR. WM. WYATT, of Burnside, near Adelaide, has

resigned his appointment as a member of the South Australian Medical Board.

TASMANIA.

DR. A. B. CROWTHER, of York House, Launceston, has removed to Hobart.

At a public meeting held in Hobart, on April 20, an influential committee was appointed to collect subscriptions for a public memorial to the late Dr. W. L. Crowther, M.L.C.

VICTORIA.

At the ceremony of the annual commencement of the Melbourne University, held in the Wilson Hall, on Saturday, April 11, in the presence of a large and influential assembly, the following degrees in Medicine and Surgery were conferred:—Bachelor of Surgery.—Alfred Purdue Vaughan, Alexander Sydney Joske, Charles George Kent, Harry Findlay Main, William Patrick Murphy, Crawford Henry Mollison, Melrose Mailer, James M'Imery Pardey, Noel Crawford Atterbury Vance. Doctor of Medicine.—James William Florance, William Moore, Frederick James Owen. Master of Surgery.—William Moore.

THE Vice Chancellor of the Melbourne University, at an adjourned meeting of the council, held on April 20, submitted the report of the committee to whom was referred.—(a) The report of the Faculty of Medicine concerning Medical education; (b) The letter of the Melbourne Hospital committee proposing that the University should collect the fees for the physicians and surgeons of the hospital; (c) Letter from Dr. Springthorpe suggesting a new course for degrees in medicine and surgery.

It was to the following effect:—

"The committee have the honour to inform the council, that they have carefully considered the matters referred to them, and after obtaining in a succinct form the opinion of the Medical Faculty thereon, beg to recommend:—

"1. That the report of the Medical Faculty, dated April 1, 1885, be adopted and carried into effect by the council.

"2. That the University should collect the fees to be paid by the students for the medical aid and surgical practice at the Melbourne Hospital.

"It will be observed that, to carry out the recommendations of the Medical Faculty, some alteration will have to be made in section 1, clause 1, of the University Extension of Teaching Committee's report, headed, 'Additional Teaching, &c.':—(1) By rearranging the courses on chemistry; and (2) a slight alteration will be required in clause 2 of the same section in regard to the teaching of practical biology. In conclusion, your committee beg to remind the council that if the scheme for medical education recommended by the Faculty of Medicine in their report be adopted, provision must be made for the payment of £250 per annum to a lecturer on advanced therapeutics, dietetics, and hygiene.

"A. C. BROWNLESS, M.D., Chairman."

After some discussion, the consideration of the report was deferred to a future meeting.

THE annual paper chase of the Medical School of the Melbourne University took place on April 24, the run being from Brighton Beach to Mordialloc. The hare and hounds left Melbourne by the 2.4 train, and on arrival at the beach no time was lost in starting the hunt. At four minutes past three the hares (Messrs. Seal, Lawrence, and Horne) were sent away, and 15

minutes after the hounds, 19 in number, received the starter's signal. For the first mile the country was open, then the bracken and bush fences began to give trouble, and some stiffish hills caused a remarkable thinning in the first few miles. A large market garden was then crossed, and when the Cheltenham-road was reached all seemed straight running, but the wary hares had made several detours, and by doubling back retarded some of the hounds. The sea was eventually sighted, and the hares perceived a short distance ahead entering Mordialloc, which was reached in safety. A sea bath was a fitting completion to a run of 14 or 15 miles over very rough and thickly wooded country. Subsequently a dinner was provided for the ninety-nine persons present, Dr. Shields being in the chair, and Dr. Springthorpe in the vice-chair. After the usual loyal toasts a long and entertaining programme of songs was presented. The first hound (Mr. Colquhoun) was presented with a medal, the gift of Dr. Springthorpe.

THE Victorian Branch of the St. John Ambulance Association, held a public meeting in the Athenæum-hall, Melbourne, on April 27. Sir Wm. Clarke, Bt., presided, and His Excellency the Governor, who is a Knight of the Order of St. John of Jerusalem, addressed the meeting, commending the objects of the association, and gave some interesting facts to show how much the instruction it imparted was likely to benefit the wounded in cases of emergency. He afterwards distributed certificates of merit to those deserving them, among whom were several members of the Ambulance Corps of the Railway department. An exhibition of ambulance work was also given, under the direction of Dr. R. B. Warren, the hon. secretary of the association.

ON April 19, it was reported to the Central Board of Health, that a little girl living at Hotham, a suburb of Melbourne, who was suspected to be suffering from smallpox, really had a modified form of that disease. She was not removed to the Sanatorium, but the premises were strictly quarantined, and all the inmates re-vaccinated. She had been attending a State school at Hotham up to the time of showing the eruption. Several other suspicious cases are reported from the same locality. Some days after receiving this information, the Central Board of Health requested Drs. Shields and Tweeddale to investigate the case and report on it. The gentlemen referred to, accompanied by Dr. Girdlestone, broke the quarantine and examined the patient, when they agreed that she certainly was not suffering from varioloid disease. The Central Board of Health then wrote to the local board, suggesting that they should get further evidence in support of the report of the local medical officer on which the quarantine had been established, or to abolish it. This recommendation has caused the relations between the two bodies to be rather strained.

THOMAS MORGAN ANDREWS, L. et L. Mid., R.C.P., Ed., L.F.P.S., Glasg., 1879, who arrived in the colony about 15 months ago, was reported to have committed suicide, at his residence, 65 Kerr-street, Fitzroy, Melbourne, on April 12. The deceased cut his throat with a razor, the wound extending completely across the throat.

THE HON. DR. BEANEY, M.L.C., was a passenger to Europe by the M.M.S. "Sydney," on April 26. Prior to his departure, he purchased a site on which to erect homes for poor consumptive patients. The situation is at Riddell's Creek, where Dr. Beaney considers the climate most suitable for persons suffering from chest disease. The area is about 50 acres, on which, according to a sketch plan prepared by Messrs. Evans and Birtwistle, architects, there are to be erected ten cottages, which will

accommodate ten patients each. This system is considered the best, and combines semi-privacy with perfect ventilation, the partitions between each bed being about 8ft. high. The grounds will afford ample room for recreation, and useful occupation to such patients as can do a little light work.

MR. EDWIN JAMES BENNETT, L.S.A., Lond., 1834, J.P., died at his residence, Lazzell-street, Stawell, on April 23, after a protracted illness, at the age of 72, never having recovered from the effects of the exposure caused by his fall down a deserted shaft, on the night of the 21st February, 1884, and remaining in the shaft until rescued next day. The deceased came to Stawell in 1859, having come out to the colony in 1855, as medical officer of the barque Norway. He practised his profession at Fitzroy, and was a member of the first municipal council of that suburb. Mr. Bennett, at the time of the accident, held the position of resident medical officer in charge of the Stawell Hospital and Benevolent Asylum.

DR. W. J. BIRD, of Coburg, has removed to Boort, 176 miles N.W. of Melbourne.

DR. A. W. EDDIE, late of Bombala, (N.S.W.) has removed to Bendoc, a post town in Gippsland.

JOHN PATRICK FITZGERALD, J.P., M.B., 1876, Ch. B., 1879, Melb., died at Shepparton, after an illness of nine days, on April 27, from inflammation of the lungs and chronic bronchitis. The deceased had been a resident of the town for the past eight years, and held the appointments of District Health Officer and Public Vaccinator; at one time he was a Resident Surgeon of the Melbourne Hospital, also Medical Officer to the Mooroopna Hospital. He leaves a wife and family.

DR. CÆSAR KIESER, M.D., Wurzb., 1841, formerly of Macarthur in the Western district, and for the last seven years residing at Preston, near Melbourne, is dead.

DR. F. H. MAIN, a native of the colony, has commenced practice at Malmsbury, in an agricultural and mining district, 63 miles N.W. of Melbourne.

DR. F. H. MEYER, late Resident Medical Officer of the Melbourne Lying-in Hospital, has commenced practice at Warwick House, corner of Grattan and Drummond streets, Carlton, a suburb adjoining Melbourne.

DR. J. P. MONTGOMERY, late Resident Medical Officer at the Melbourne Hospital, has commenced practice at Traralgon, in a mining district, 113 miles E. of Melbourne.

ROBERT RICHARD RIMINGTON, M.B. et Ch.B., Melb., 1883, late Public Vaccinator and Health Officer for the shire of Yarrowonga, died at Brunswick-street, North Fitzroy, near Melbourne, on the 9th May, at the early age of 29 years.

DR. ROBERT SMITH, late of Linkinhorne, Cornwall, has commenced practice at Yarrowonga, on the river Murray, in an agricultural and pastoral district, 160 miles N.E. of Melbourne.

DR. FRANK TAYLOR, late house-surgeon of the Teignmouth Infirmary, England, has settled at St. Arnaud, an important town in a pastoral and mining district, 165 miles N.W. of Melbourne.

WESTERN AUSTRALIA.

WOODMAN'S POINT, near Fremantle, has been selected as a site for a Quarantine station; the necessary buildings are now being erected.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Vallée, Louis, L.R.C.P. & R.C.S., Edin., 1884.
Thurston, William French, L.R.C.P., Edin., 1866; L.S.A., Lond., 1866; M. & L. Mid., R.C.S., Eng., 1866.
Service, John, L.R.C.P. & R.C.S., Edin., 1878.
Newman, Dewitt Clinton, M.D., Cooper Med. Coll., San Francisco, U.S.A., 1883.

NEW ZEALAND.

Mahon, Henry Greenwood, L.R.C.S., Irel., 1880; L. Med. and Mid., K.Q.C.P., Irel., 1881.
Bewes, Edward Austis, L.R.C.P., Edin., 1863; M.R.C.S., Eng., 1863.

QUEENSLAND.

Hare, Francis Washington Everard, M.R.C.S., Eng., 1879; M.B. Dur., 1884.
Whitworth, Edward, M.R.C.S., Eng., 1874; L. & L. Mid., R.C.P., Edin., 1876.

SOUTH AUSTRALIA.

Cuscaden, George, L.R.C.P. & R.C.S., Edin., 1880.

VICTORIA.

Lerew, Frederick William, M.R.C.S., Eng., 1880; M.B. & Ch.M. Aberd., 1881.
Smith, Robert, L. & L. Mid., R.C.S., Edin., 1881; L.A.H., Dubl., 1880.
Taylor, Frank, M.R.C.S., Eng., 1877; L.S.A., Lond., 1877.
Eddie, Arthur William, M.B. & Ch.M., Aberd., 1882.

Additional Qualification registered:

Fitzgerald, Thomas Naghten, Melbourne, F.R.C.S., Irel., 1884.

MEDICAL APPOINTMENTS.

Bancroft, Thomas Lane, M.B. & Ch.M., Edin., to be Resident Surgeon of the Hospital for Pacific Islanders at Geraldton, also Government Medical Officer at Geraldton, Qu.
Barnard, Charles Edward, M.D. & Ch.M., Lond.; L.R.C.P., Lond.; M.R.C.S.E., to be a Surgeon in the Reserve Branch of the Tasmanian Volunteer Force.
Bird, William Joshua, M.B., Melb., to be Public Vaccinator at Boort, Vic.
Brown, William Henry, M.R.C.S., Eng., & L.S.A., Lond., to be Public Vaccinator and Health Officer for Rosedale, Vic.
Campbell, James, M.D. & Ch.M., McGill Univ., Montreal, to be Public Vaccinator for Broadmeadows, Bulla, and Kellor.
Cheetham, Francis, L. & L. Mid., R.C.P., Edin., to be a Surgeon in the Victorian Naval Forces.
Cullinan, Ralph, L.F.P.S., Glas., to be Public Vaccinator for Myrtleford, Vic.
Cuscaden, George, L.R.C.P. & R.C.S., Edin., to be Public Vaccinator, also to act as Medical Officer to attend to the destitute poor and aborigines within the district of Port Wakefield, S.A.
Eddie, Arthur William, M.B. & Ch.M., Aberd., to be Public Vaccinator for Bendoo and Bonang, Vic.
Giblin, Edward Owen, M.D. & Ch.M., Aberd., M.R.C.S.E., to be a Surgeon to the Southern Tasmanian Volunteer Rifle Regiment.
Henderson, Colin, M.D. & Ch.M., Aberd., L.R.C.P. & R.C.S., Edin., appointed Resident Surgeon at the Bathurst Hospital, N.S.W.
Hooper, John William Dunbar, L.R.C.P. & R.C.S., Ed., appointed Resident Medical Officer at the Lying-in Hospital, Melbourne, Vic.
Haden, Edward Oreswell, M.R.C.S.E., to be Medical Officer to attend to the destitute poor and aborigines within the district of Lacedo, S.A.
Innes, Francis William, M.B. & Ch.M., Edin., to be Acting Health Officer for the Port of Geelong; also an additional Public Vaccinator for the district of Tauranga, N

Jordan, Thos. Furneaux, M.R.C.S.E., to be Public Vaccinator for Ballarat West, Vic.
Kent, Charles George, M.B. & Ch.B., Melb., appointed Resident Medical Officer at the Melbourne Hospital.
Keyworth, John White, M.D., Lond., M.R.C.S.E., appointed a member of the New Zealand Medical Board, under "The Military Pensions' Act," 1866.
Landvoigt, Frederick, M.D., to be Public Vaccinator for Wodonga, Vic.
London, Alfred Austin, M.D., Lond., M.R.C.S.E., elected Hon. Medical Officer to the Adelaide Sick Children's Hospital, S.A.
Lewis, Thomas Hope, M.R.C.S.E., to be an additional Public Vaccinator for the Auckland district, N.Z.
Main, Henry Findlay, M.B. & Ch.B., Melb., to be Public Vaccinator at Malmesbury, Vic.
Mohs, Ernst Johann Rudolph, M.D. & Ch.D., Berl., to be a Surgeon in the Queensland Defence Forces.
Mollison, Crawford Henry, M.B. & Ch.B., Melb., appointed Resident Medical Officer at the Melbourne Hospital.
Montgomery, John Park, M.B. & Ch.B., Melb., to be Public Vaccinator for Traralgon and Morwell, Vic.
Nicoll, Alexander, M.B. & Ch.M., Aberd., to be Government Medical Officer at Tambo, Qu.
Nicoll, James Robert, M.B. & Ch.M., Aberd., to be Assistant Surgeon of the Hospital for Pacific Islanders at Mackay, Qu.
Pardey, Charles William, M.B. & Ch.B., Melb., to be Government Medical Officer and Vaccinator for the district of Hillston, N.S.W.
Pardey, James Melmer, M.B. & Ch.B., Melb., appointed Resident Medical Officer at the Melbourne Hospital.
Semple, William Henry, M.D., Ed., L.R.C.S., Ed., to be Health Officer for the shire of Kilmore, Vic.
Shields, Charles James, M.B. & Ch.B., Melb., appointed Resident Medical Officer at the Lying-in Hospital, Melbourne, Vic.
Vance, Noel Crawford Atterbury, M.B. & Ch.B., Melb., to be Public Vaccinator for Bacchus Marsh, Vic.
Wilkinson, William Cleland, M.B. & Ch.B., Dub., L.K.Q.C.P., Irel., to be Public Vaccinator for Preston and Epping, Vic.
Young, George Jacob, M.B. & Ch.M., Edin., to be Public Vaccinator for Horsham, Vic.

CORRESPONDENCE.

A CORRECTION.

(To the Editor of the A.M.G.)

SIR,—In your last issue, reporting the discussion on the sublimate of mercury antiseptic, mentioned in my paper on Herniotomy, there is an important error, the quantity of water being stated at 3ij. instead of Oij.

In order to avoid mistake, I insisted on the expression of the proportions in percentages, or decimal fractions, and I beg to repeat that the quantities are:

Sublimate	$\frac{1}{10}$ per cent., or	0.020
Sodium chloride	$\frac{1}{2}$ "	0.750
Distilled water	100	100.000

Of course anyone paying attention to the subject must see that the solution given in the second column of page 168 of the A.M.G. for April 15, 1885, is of a poisonous strength.

I am, Sir,

Your obedient servant,

JAMES T. RUDALL, F.R.C.S.E.

121, Collins-street East, Melbourne.

THE AUCKLAND HOSPITAL COMMITTEE AND DR. BOND.

(To the Editor of the A. M. G.)

SIR,—I forward you report of a late meeting of the Auckland Hospital Committee for your perusal, and I beg to draw your attention to one remark—"The chairman said his own view of the position was that Dr. Bond should not remain as surgeon to the Hospital on other grounds, not particularly those arising on the inquiry." Now, Sir, I do not know Dr. Bond, but I am awake to this being a side issue that is not allowed to be tried, but must be taken as the chairman's dictum without question. Let any person read the history of the Auckland Hospital disturbances, present or past, and they will not be likely to differ from the conclusion I have arrived at, viz., that the chairman is Mr. McKechnie, that he is a lawyer, that he is very clever, and that if his prejudices, on other grounds not particularly arising from an inquiry, are trespassed against, that he is capable of pulling the strings and making the rest of the committee caper to his own tune. That some of the rest of the committee, however well meaning, are narrow-minded, must also be patent from it appearing that the patient Smith, who had suffered so severely from the cruelty of the house surgeon, is stated by the mayor to be not only very clever but very fat. Captain Daldy, also, who is a capital judge of a whale lance, shows professional acumen of an original character, when he says, "for Dr. Bond to put a patient under chloroform without any other medical man being present, was sufficient to show he should be got out of there as soon as possible." Your correspondent pleads guilty to having done the same for dentists or himself in several hundred cases, without considering himself either singular or criminal, until an experienced South Sea skipper issued his fiat.

I remain, MAORI.

[We do not think that Dr. Bond has been treated by the committee of the Auckland Hospital in that fair and impartial manner which the executive body of a public institution should exercise towards all its officers, especially to one who holds the responsible position of resident medical officer. The special charge against Dr. Bond was one of cruelty and neglect in the treatment of a patient named Smith, who, however, does not seem to have suffered much mental or bodily injury, as he is described by more than one member of the committee as being at the present time "very clever and very fat." This charge seems to have been initiated by one of the visiting staff, Dr. Richardson, who, however, in a most extraordinary manner, declined to give evidence at the enquiry instituted to investigate the affair. Four members of the visiting staff, namely, Drs. Hooper, Knight, MacMullen, and Coom, in a letter to the committee, expressed their confidence in Dr. Bond, emphatically condemning the conduct of Dr. Richardson; and saying that the charges made against Dr. Bond not having been proved they considered the request made to him to resign his position uncalled for and unjust. This committee seems to have very extraordinary ideas as to its duties as a tribunal; for, according to the remarks of its chairman and some of the other members, it is prepared to try its employees on one charge and, failing the substantiation of this, to condemn them on others which have not come before it. Some members seem to be intelligent men animated by a spirit of fairness and justice; but, taking the body as a whole, if we are to judge it by published reports of its proceedings,

we can only congratulate the people of Auckland on the fact that its power is on a par with its capacity, and that any action which it takes is liable to reversal on appeal to the Government of New Zealand from whom Dr. Bond has asked for a commission of enquiry. A convincing proof that Dr. Bond has not been greatly blameworthy in the matter, is found in the fact, that in the action brought against him by the patient Smith the verdict was in his (Dr. Bond's) favour, and the plaintiff was ordered to pay costs.—Ed. A. M. G.]

THE CHRISTCHURCH (N.Z.) HOSPITAL ENQUIRY.

(To the Editor of the A.M.G.)

SIR,—On the 2nd February I had the honour "to request that you would be good enough to withhold from publication in your journal any communication which you might receive with regard to an enquiry, still *sub-judice*, concerning an operation which was recently performed at the Christchurch hospital, until the whole of the evidence is published, when I shall send you a copy."

The case is still undecided; a Royal Commission has been applied for by Dr. Nedwill, and the Colonial Treasurer has stated, at a public meeting in Christchurch, that "Dr. Grabham is going to investigate the matter."

This will explain to you why I have not forwarded a copy of the evidence as taken before the Hospital Board.

I am astonished that without this evidence, and without asking me for any explanation, you should have, on mere "newspaper and other reports," committed yourself to a line of criticism entirely unjustified by the evidence given at the partial enquiry already held.

I have the honour to be, Sir,

Your obedient servant,

P. DOYLE, M.D.,

President Canterbury Medical Society.

Christchurch, N.Z., April 12.

(To the Editor of the A.M.G.)

SIR,—My attention has been directed to a notice in your journal of the 15th of February, and also to your leading article in the same paper of the 15th of March, with reference to an enquiry which was recently conducted at the Christchurch hospital.

For the present I shall content myself by saying that you are either in ignorance of the facts of the case, or you have used your columns to malign me, and to endeavour to injure me. I am, Sir, yours, &c.,

COURTNEY NEDWILL, M.D.

Christchurch, N.Z., April 14.

[We can have no other desire than to serve the best interests of the profession. We have no acquaintance with any person concerned; our remarks, therefore, were, and will be made from an absolutely disinterested standpoint, and they were what we believed the circumstances of the case necessitated. Should further information give us reason to think we have been unjust in our criticism, we shall have no hesitation in saying so. We may, however, remark that we think it somewhat unreasonable to be asked to refrain from criticising a case which occurred several months since, in the hope of receiving the report of a problematical enquiry, to be held at some unknown and very future time.—Ed. A.M.G.]

COCAÏNE, AN ANÆSTHETIC TO THE EYE.

(To the Editor of the A.M.G.)

DEAR SIR,—Until to-day I have performed 11 operations on the human eye with the help of Cocaine, viz.: 3 cataract, 3 strabismus, 2 iridectomy, 1 pterygium, 1 blepharophymosis, 1 trichiasis. Cocaine muriat. (3 drops of a 2 % lotion) was locally applied about ten minutes previous to operation, and in all cases the sensation of pain was reduced to a great degree.

The operation for strabismus (in which the catching of the muscle with a hook and severing the muscle from the sclerotic is generally very painful to the patient) was nearly painless, only a pressing sensation was experienced. During the linear extraction of cataracts, the only part which caused pain was the iridectomy. The removal (transplantation) of pterygium gave no pain whatever, while the cut with the scissors in the operation for blepharophymosis was said to be hurting; but this was natural, because the Cocaine could not anæsthesise the outer margin of the lid. The trichiasis operation, which lasted over 20 minutes, was splendidly stood by the patient, although she said it was somewhat painful, yet she thought it would be much more so. One application of the lid elevator, which, as a rule, is causing so much annoyance, was in no instance complained of as being disagreeable.

In giving the above facts, I wish to help to draw the specialist's attention to Dr. Koller's discovery, as simple as it is startling. The readers of the A.M.G. will probably know by this time that Cocaine is the alcaloid of the leaves of *Erythroxylon Coca*, a bushy growth which is found in South America, especially in Peru and Bolivia, where the extract of such leaves is said to have been in use for centuries as an antidote for pain. The medicament which I have been using, is from Dr. Simons, Apothecary, of Berlin, where it is prepared also in gelatine plates, each containing $\frac{1}{5}$ milligramm. The price of one grain is not quite 3 shillings; but one grain goes a long way in a 2 % lotion, of which 2 or 3 drops only need to be used to produce the desired effect. A stronger lotion than 2 % has no special advantage. The highest degree of local insensibility seems to be gained about 10 or 15 minutes after application. By re-applying the drops one can prolong the anæsthetic effect as long as desirable. In all the cases mentioned mydriasis was noticed, but it was neither of a high degree nor of a long standing. Obnoxious influences of Cocaine on the healing of the wounds was not experienced.

B. SCHWARZBACH, M.D., L.F.P.S., Glasg.

Wellington, New Zealand, March 30.

ADVERTISEMENT OF DIPLOMAS BY AN UNREGISTERED PRACTITIONER.

(To the Editor of the A.M.G.)

SIR,—Referring to your remarks attached to my last letter in your columns, I beg to inform you that the portions of the letter quoted in those remarks applied simply to the means used in obtaining my American qualification, and not those in any way attaching to the Edinburgh ones. These latter, I reiterate, I do possess, and they would have been presented last registration day, only that I was required to give five days' notice to the Secretary of the Board, and only receiving the form telling me this on the 4th ult., the Registration day being the 8th, I was unable to do so. In proof of what I assert, in a few days time it is my intention to send my diplomas to my Solicitor in Sydney, with instructions to submit them to you, and then perhaps, as "seeing is believing," you will be inclined to do me justice, and to extend to me a little of that charity which—if my memory is not *too bad*—I believe most of us have been taught as being right to exercise.

I am, &c.,

S. E. HERBERT.

WELLINGTON, N.S.W., 13TH APRIL.

P.S.—As to the "gullibility of the N.S.W. Board," I had no wish to test it. My U.S. diploma is recognised in the States, and such being the case—having studied hard for it—I expected that it would be received here. As to the pecuniary circumstances which prevented my obtaining *English* qualifications, the same circumstances need not necessarily (as you seem to infer) have interfered with my doing so elsewhere.

S.E.H.

[Though a month has passed since Mr. S. E. Herbert wrote the above letter, we have not yet been favoured with a sight of either the solicitor or the diplomas spoken of in it. Another registration day has also passed, and the diplomas are still unregistered. With regard to the U.S. diploma, viz., that of the University of Philadelphia, which is the one our correspondent desired to register, we can only quote from the letter of the English Consul at Philadelphia, who, in a letter dated July 26, 1884, says:—"I have to inform you that the University of Philadelphia is no longer in existence, its charter having been cancelled by the Government of Pennsylvania after a disgraceful existence of many years. *Diplomas purporting to issue from such an institution are bogus and a fraud upon the community.*"—ED. A.M.G.]

MEDICAL CERTIFICATES.

(To the Editor of the A.M.G.)

DEAR SIR,—In the interests of the profession, I would be glad if you would bring before the readers of your useful and important journal, the following case. I will merely state the facts, and ask you to deal with the matter (if you see fit) in your usual able manner.

I was attending a patient in this town named Wm. Kingston, who was suffering from malarial fever and bronchitis. He had been summoned as a juror for the Supreme Court. During the course of treatment, I considered it necessary for his complete recovery, that he should go farther south for change, and ordered him away accordingly. He went south about a week before the sitting of the court, and before going, asked me to give him a certificate to leave with his friends, to pre-

sent to the judge as an explanation of his absence from the court. I gave him the certificate, in it stating what he had been suffering from, and stating that I had ordered him south for the benefit of his health, and that he could not attend the jury. When this certificate was presented to the judge, his honor (Justice Cooper) ruled that it was insufficient excuse and fined Kingston £2, and stated that it was necessary for the medical man to appear personally and verify it on oath.

The man's friends waited on me and requested me to attend the court and take the necessary oath. This I declined to do on the grounds:—1st. That I considered a medical certificate from a legally qualified and registered medical practitioner, ought to be sufficient; 2nd. That I considered His Honor in refusing to accept my medical certificate, cast an aspersion on my integrity and veracity, and that of the profession generally; 3rd. That I believed a medical certificate was usually accepted and deemed sufficient in similar cases; 4th. That it was accepted without question in much more important instances, *e.g.*—death certificate; 5th. That His Honor's refusing to accept a medical certificate, tended to shake the confidence of the public in the integrity and honour of the medical profession.

On the following day His Honor inflicted a fine of £5, and stated that he would remit the fine if the medical man made the required affidavit.

The next day Kingston was fined £10, His Honor stating, "That Dr. Macartney's conduct in the case reflected very little credit upon him. If he had agreed with the absent juror and allowed him to go away on account of some small illness, and had sent in the certificate with the object of misleading the court, he was guilty of a very grave offence. If the absent jurymen was really ill and had asked Dr. Macartney to certify to his ill-health, and to have him excused from attending the court—for which service, he (Dr. Macartney) might probably have been paid—then Dr. Macartney was bound in honour to appear.

He (His Honor) declared that the certificate presented was insufficient excuse, and he would not accept it. Dr. Macartney had laid himself open to the suspicion that he had sent in an improper certificate, and that he feared to attend the court and verify it upon oath.

He could not show favoritism and would adjourn the court, so far as the decisions against the absent jurymen were concerned, from day to day, in order to allow them to clear themselves; at present one of the jurymen was under suspicion."

I may state that the man's wife attended in court and offered to make an affidavit as to her husband being unable to attend, through sickness, but she was refused.

I may state also, that a subscription is being raised to pay the fine, and that most of the medical men of this town are subscribers.

Trusting you will excuse me troubling you so much in this matter, I am, dear Sir, yours truly,

Geo. W. Macartney, L.R.C.P. et S., Edin.

Townsville, Queensland, April 26.

[We think that the question of what is sufficient evidence as to the inability of a juror to attend a court to which he has been summoned is a matter of great interest to the public, and should be authoritatively decided by a rule of court. Failing this, it must of necessity be uncertain, depending, as it does, on the decision of each individual judge, who appears to have authority to conduct the court over which he presides as he thinks fit. This is most unsatisfactory, the course to be pursued being likely to vary, certainly, with each judge, and frequently with the same judge.—ED. A.M.G.]

MEDICO-LEGAL.

(To the Editor of the A.M.G.)

SIR,—In your last issue I notice a letter from Dr. Reid, of Port Germein, South Australia. The case he reports is very interesting, and is somewhat similar to one which came under my notice while I was House Physician at the Great Northern Hospital, London.

A boy, aged six years, was brought in by his mother, who said a hansom cab had knocked the child down, and that a wheel had passed over his chest. She also stated that he had lost a lot of blood from the month, but of this I could find no sign. There were not any bruises about the child's body, and he was able to walk, although suffering greatly from fright. About an hour after admission I found that the respirations were rapid and shallow, and that there was a large patch of dulness on the right chest. Six hours after his admission the child suddenly died. A post-mortem examination revealed an extravasation of blood into the right pleural cavity, and a rent about two inches long in the lower lobe of the right lung. Not one of the ribs was broken. I am, Sir, very truly yours,

THEO. M. KENDALL,

B.A., Sydney, L.R.C.P.E., L.R.C.S., L.M.

50 Macleay Street, Sydney.

TYPHOID FEVER.

(To the Editor of the A.M.G.)

SIR,—I was much interested in reading the debate on the treatment of typhoid fever before the South Australian Branch of the B.M.A., in the March number of the A.M.G. I think that the indefiniteness with regard to treatment which was there expressed may be in great part traced to a like vagueness in diagnosis. There appears to me to be a great tendency on the part of the medical profession just now to call all cases of continued fever "typhoid fever." I think the latter term should be restricted to cases in which there is distinct enteric lesion, instead of which I have repeatedly seen cases of fever, having no special enteric symptoms, and lasting only a week or even less, styled typhoid by the medical man in attendance. Now, simple continued fever is a very common disease in England, and I take it as extremely probable that a parallel disease, having more marked symptoms (higher fever, &c.), owing to the greater heat of the climate, is equally or more common in the colonies. I take it that the larger proportion of cases formerly denominated "colonial fever" were of this nature, *viz.*, simple continued fever, a small proportion of them being genuine typhoid. I have seen cases of fever that had no special intestinal symptoms, no spotty eruption, and that were well in less than a fortnight, styled typhoid by the medical man in attendance, and this I take to be a grave error, and liable to throw us back into the chaotic state that existed before Jenner differentiated the continued fevers. Another highly important point is to be sure to exclude any possible malarial origin. Apologising for these remarks,

I remain,

Yours faithfully,

JAS. HUDSON, M.B. (Lond.).

Nelson, New Zealand.

REPORTS OF SOCIETIES.

MEDICAL SECTION OF THE ROYAL SOCIETY OF N. S. WALES.

A MEETING of the medical section of the Royal Society was held on April 17, in the society's house, Elizabeth-street. Dr. Mac Laurin occupied the chair, there being a good attendance of members. The chairman, in opening the meeting, stated that the council of the society had made a grant of £50 for the purchase of books for the medical department of the society's library, and the following had been selected:—Catalogue of the Pathological Department of the Museum of the Royal College of Surgeons; Reports of the Medical Officer of the Privy Council; Transactions of the Pathological Society, the Obstetrical Society, and the Medico-Chirurgical Society. The chairman also impressed upon members the necessity of providing papers to be read, as it would be of no use for them to meet unless they had subjects to discuss.

A ballot for the election of officers was then taken, with the following result:—Chairman, Dr. Mackellar; Committee, Drs. Oram, Manning, Mac Laurin, Chambers, Anderson-Stuart, and Knaggs; Secretaries, Mr. T. Evans, M.R.C.S., and Dr. Hurst. Dr. Mac Laurin then vacated the chair, which was taken by Dr. Mackellar, who returned thanks for the honour conferred upon him, and urged upon the members not only to provide papers, but to come and hear them read.

Dr. W. C. Wilkinson read a paper on the "Cholera bacillus of Koch and its relation to cholera." In the course of it he stated that Klein had gone out of his way to make a number of very general refutations of Koch's theory, when a single specific one would have been sufficient to disprove the specific nature of Koch's bacillus. He did not hold that the position of the latter was unassailable, because the cholera bacillus had never been found in the blood or organic tissues. There was no doubt, however, that Koch's discovery had a great diagnostic value, but it was to be hoped that in Australia they would never be required to put it to the proof. He thought, however, that the study of bacteria was of sufficient importance to cause attention to be paid to it here, and he remarked that in Berlin it formed a department of the Health Office. A vote of thanks was accorded to Dr. Wilkinson for his interesting lecture.

Dr. Anderson-Stuart read a paper on "The disposal of typhoid excreta by cremation." He pointed out the danger arising from burying this matter, and contended that all danger of subsequent infection was removed where the matter was destroyed by fire. He deplored the sanitary state of so beautiful a city as Sydney, and said it behoved everyone to compete with the terrible malady that was scourging, not only the city proper, but also the suburbs. He alluded to the drainage and water, and laid great stress on his belief that the disease was spread through pipes. He had no doubt at all that typhoid was far more dangerous, disastrous, and insidious than small-pox, but because it was less marked in its course and appearance, it was treated in a light manner.

The Chairman, in commenting on the danger of water pollution from such sources as had been referred to, stated that nightsoil was being deposited behind Mount Renny and Mount Steele, and only a few hundred yards from the boundary of the watershed. A hill intervened between the locality made use of and the watershed, but as it consisted of silica it could not be regarded as a very reliable filter.

Votes of thanks were accorded to Dr. Anderson-Stuart, and to the retiring chairman, and the meeting then adjourned.

PUBLICATIONS RECEIVED.

TWENTY-eighth Annual Report of the Council of the Pharmaceutical Society of Australasia, Melbourne, 1885.

EUCALYPTOGRAPHIA.—A descriptive atlas of the Eucalypts of Australia and the adjoining Islands. By Baron Ferd. von Mueller, K.C.M.G., M.D. et Ph. D., F.R.S., Government Botanist for the colony of Victoria. 10th Decade. Melbourne: John Ferres, Govt. Printer, 1884.

DISEASES OF THE SPINAL CORD.—By Byrom Bramwell, M.D., F.R.C.P., Ed., 2nd ed. with 183 illustrations. Edinburgh: Young J. Pentland, 1884.

SMITHSONIAN REPORT for 1882. Washington: Govt. Printing Office, 1884.

EXPERIMENTAL Researches on Cicatrization in Blood-vessels after Ligation.—By N. Senn, M.D., of Milwaukee, Wisconsin, U.S.A. Extracted from the Transactions of the American Surgical Association, Vol. II., 1884. Philadelphia: Collins, 1885.

A PRACTICAL Treatise on Palatable Prescribing, containing the favourite formulæ of the most eminent English, French, German, and American medical and surgical authorities of the age, and embracing a resume of the most eligible prescriptions for the administration of recent additions to the materia medica.—By B. W. Palmer, A.M., M.D., author of "Favourite Prescriptions of Distinguished Practitioners:" member of the New York County Medical Society, of the New York Medico-Legal Society, &c. Detroit, Mich.: Geo. S. Davis, 1885.

This book, containing the most eligible prescriptions for the administration of those new remedies which recent research has added to the materia medica, and embodying, as it does, the favourite formulæ of many eminent medical authorities, such as Marion Sims, S. D. Gross, Austin Flint, Gaillard Thomas, F. Barker, Bartholow, Fothergill, Da Costa, Brown Sequard, Hammond, Niemeyer, Lister, Erichsen, Trousseau, Ricord, Erasmus Wilson, Tilbury Fox, Tilt, Quin, Berkeley Hill, Murchison, and many others, will, we are sure, receive a warm welcome from the mass of the profession, especially as it supplies a kind of information available for immediate use in practice which cannot be acquired by the individual practitioner, except by laborious research through medical literature. We warmly recommend this useful work to the profession in Australia.

ELECTRICITY AND ITS MANNER OF WORKING IN THE TREATMENT OF DISEASE.—A thesis for the M.D. degree of the University of Cambridge. By W. E. Steavenson, M.D., M.R.C.P., &c. To which is appended an Inaugural Medical Dissertation on Electricity, written in Latin, by Dr. Robert Steavenson, in 1778. London: J. & A. Churchill, 1884.

MEDICAL GUIDE TO THE MINERAL WATERS OF ROTORUA.—By T. Hope Lewis, M.R.C.S.E., late Government Resident Medical Officer, Auckland, N.Z. H. Brett, 1885.

SIXTH ANNUAL REPORT OF THE STATE BOARD OF HEALTH OF ILLINOIS. With two appendices: (a) Conspectus of the Medical Colleges of America; (b) Official Register of Physicians and Midwives in Illinois. Springfield, Illinois: H. W. Rakker, State Printer and Binder. 1884.

INTERNATIONAL MEDICAL CONGRESS, Ninth Session, to be held in Washington in 1887. Rules and Preliminary Organization. Washington, D.C. 1885.

REPORTED MORTALITY FOR THE MONTH OF MARCH, 1885.

Cities and Districts.	†Population.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from							
				Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Child-bearing.
N. S. WALES.											
Sydney	103,379	243	108	...	2	6	...	14	22	28	1
Suburbs	120,832	313	189	...	4	8	1	20	35	14	1
NEW ZEALAND.											
Auckland	28,208	62	25	...	...	...	...	2	18	3	...
Christchurch.....	16,354	12	4	...	...	...	...	...	2	1	1
Dunedin	24,824	35	3	...	...	...	...	1	4	6	...
Wellington	22,836	32	8	...	...	3	1	1	2	3	1
QUEENSLAND.											
Brisbane	26,557	51	25	*	...	...	...	...	...	...	...
Suburbs	9,612	27	11	...	...	...	...	...	...	...	...
SOUTH AUSTRALIA.....	318,339	369	193	1	1	6	1	20	46	23	1
Adelaide	43,969	76	31	...	...	1	...	4	11	6	...
TASMANIA.											
Hobart	28,943	39	18	1	...	2	...	...	4	4	...
Launceston.....	18,176	20	9	...	...	...	1	...	2	2	...
Hospitals, Asylums, Gaols, &c. .	1,138	25	...	...	...	...	...	...	...	...	...
Country Districts.....	85,358	64	...	2	...	1	4	...	11	...	...
VICTORIA.											
Melbourne	65,791	112	261	...	1	8	3	23	48	89	4
Suburbs	238,618	518		...	...	...	...	...	...	...	...

* The Official Monthly Report on the Vital Statistics of Brisbane and Suburbs does not show the number of deaths from the various diseases
† The population of N. S. Wales, Victoria, Adelaide, and Queensland, is that of the census of 1881; New Zealand, South Australia, and Tasmania show the estimated population at the present date.

METEOROLOGICAL OBSERVATIONS FOR MARCH, 1885.

STATIONS.	THERMOMETER.				Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.		Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E.....	...	93·6	66·	45·8	29·925	Inches	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.....	140·	77·5	63·4	49·	...	2·360	15	69	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.....	171·	94·	76·4	59·	29·999	1·54	13	69	N.E.
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.....	...	...	...	...	...	...	...	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.....	135·	82·	57·1	42·	...	1·246	15	67	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.....	...	85·	58·5	41·2	29·835	3·51	17	77	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E.....	...	80·	60·	36·5	29·922	2·74	12	68	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E.....	...	95·2	61·5	42·5	29·925	2·39	11	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E.....	...	92·	69·2	56·6	30·026	1·90	15	60	N.E.
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.....	145·	72·	60·2	46·8	...	3·430	18	87	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

TWO CASES OF EMPYEMA WITH SOME REMARKS ON TREATMENT.

(READ BEFORE THE N.S.W. BRANCH B.M.A.)

By DAVID COLLINGWOOD, M.D. & B.S., LOND.,
F.R.C.S., ENG., SUMMERHILL, NEAR SYDNEY.

THE two cases which are the subject of this paper are instances of a pathological condition by no means rare in children.

It is not, however, with any object in view of illustrating what must have been of frequent occurrence in the practice of every one of us, that I venture to bring them before the notice of the members of the branch to-night, but rather with a view to illustrating methods of procedure which are of comparatively recent date.

Case I.—Edith H., aged fifteen, was first seen by me early in January, 1884. She had been for some weeks suffering from, as I was told, pleurisy and heart disease, and had been under the care of a medical man in the west end of London. I saw her in consultation with my friend, Dr. Odillo Maher, now of Sydney. She was a delicate looking girl, tall for her age, bright and intelligent, and generally of a somewhat tubercular diathesis, closely resembling the condition of so many London bred children; the other members of the family being most decidedly unhealthy looking. Her father was of exceedingly nervous temperament, with a strong dipso-maniac tendency, and an aspect strongly forecasting the general paralysis of the insane; the mother was a subject of chronic rheumatism. Such a family history, together with the fact that my patient had already lost one eyeball from ophthalmitis following a slight wound, and with the surroundings of a London lodging-house, and the unhygienic conditions of life in a basement, form, I think you will allow, a combination decidedly unfavourable.

The patient remained under my care for several weeks, during the early part of which time an examination with the hypodermic needle showed that the fluid in the left side of the chest was simply serous; the temperature, which under the ordinary treatment had fallen nearly to normal, gradually rose again, and fluctuated between 100° and 102°. In the first week of February, the second examination with the hypodermic needle showed what the temperature already indicated, that the fluid had now become purulent. The extent of the heart disease, I may mention, I found to be limited to a considerable displacement to the right. On February 14th, an anæsthetic having been administered, I made an incision, vertically, in the posterior part of the axilla, over the sixth and seventh ribs, and deepening the incision, I removed, sub-periosteally, about an inch of the sixth and seventh ribs. I then opened the thorax by making an incision through the intercostal muscles parallel to the line of the ribs. The operation was performed under carbolic spray, with strict antiseptic precautions. The subsequent treatment consisted in syringing out the cavity frequently with weak solution of carbolic. The temperature fell to normal on the second day, and never rose again during the progress of the case. Antiseptic dressings were discontinued at the end of the third week, and at the end of the fifth week the drainage tube was removed. For a week before its removal there had been some difficulty in introducing the tube after its removal at each dressing, owing, however, only to the contraction of the skin wound. A narrow track admitted the probe about $2\frac{1}{2}$ inches at the end of the sixth week; during the seventh week this was entirely closed.

The patient's general condition had improved since the first week after the operation, and she had gained very considerably in weight.

At the end of two months examination of the scar showed that the bony tissue had been entirely reproduced, while on percussion very fair resonance could be obtained to the base on the left side.

Case II.—Cecil B., aged six, was first seen by my partner, Dr. Twynam, about the 1st Jan., 1885. He was then suffering from an acute attack of pleurisy with effusion on the left side. I first saw him with Dr. Twynam on January 6th, when

there was some abatement of the effusion, revealing the pneumonic condition of the lung beneath. He remained under my care from that date, during Dr. Twynam's absence from town, and up till the 15th continued to improve, but on that date there was extension of the pneumonic condition of the lung in an upward direction. The physical signs of a medium quantity of fluid at the base continued, and the child's temperature now rose and fluctuated between 100° and $101\frac{1}{2}^{\circ}$; with slight improvement the condition continued for the next ten days; and on the 31st of January I saw him in consultation with Dr. Creed, when the hypodermic needle confirmed the diagnosis of empyema. On the 5th February Dr. Creed administered chloroform, and with the assistance of Dr. Twynam I opened the thorax, much in the same manner as in Case I, with some slight modifications which I will describe immediately. Strict antiseptic precautions were used, and the temperature fell to normal on the day following the operation and never rose again. Subsequent treatment resembled that in Case I, with the exception that the cavity was only washed out three times. A small drainage tube was substituted for the large one at the end of the second week, and on the 5th March antiseptics were discontinued, a dressing of oakum being substituted. On the 25th March the tube was discontinued, and on the 31st the wound was perfectly healed.

The present condition—three months after the operation—you will have the opportunity of seeing to-night.

In the first of the above cases the operation consisted in the removal, sub-periosteally, of about an inch of each of two ribs (the 6th and 7th), and the opening into the thorax was made through the intervening space, so that the drainage tube, when inserted, had the interval made by the removal of a portion of rib both above and below it. By this means the tube was saved from compression by the already closely approximated ribs, or by the further approximation which would certainly follow. In that case there never was the least trouble in removing or reinserting the tube, beyond that which arose from the growth of granulations in button-like projections into the lateral openings of the tube and from the contraction of the skin wound.

In the second case, I followed, with some modification, the plan proposed and practised by Baron Von Langenbeck. His proposal was to insert the tube through a trephine opening in a rib. Such a process would be almost impossible in so young a subject as my patient, but I have seen it followed with the best results in adult patients whose interspaces were much narrowed at the time of the operation. In my case so small would have

been the opening that the tube would not have been of sufficient size to allow of the free exit of the flakey lymph which invariably escapes when an empyema is opened, and so the great object of the operation would have been defeated. Accordingly, I incised longitudinally the periosteum of three ribs, about three-quarters of an inch of each. With an aneurism needle, which I have found a most handy instrument for the purpose, I separated the periosteum from the bone to the extent of the incision—the intercostal muscles and vessels, of course, separating with the periosteum. I then snipped with scissors a piece of that membrane from the space left by the middle of the three portions of bone removed, and so opening the cavity of the thorax I was able to introduce a tube large enough to allow of the escape of all the contents of the abscess cavity—a tube larger in diameter than the breadth of a rib—and that without the least danger of injuring any intercostal structures. By removing the portions of rib above and below, the danger of compression of the tube by any slight collapse of the chest wall afterwards was obviated.

The really scientific treatment of empyema is of comparatively recent date, although the operation of opening the thorax was practised as far back as 1859, if not earlier; but I can remember, as a student, listening to the advice of an eminent lecturer on medicine, who recommended that aspiration of the thorax should be employed, and repeated, even when the pus withdrawn was decomposing, or the patient were the subject of hectic (!), while the free opening was recommended only in extreme cases, and then only with great hesitation and caution. There can be no question as to the propriety of early incision, believing, as we all must, that pus cannot be reabsorbed, but must by some means be evacuated; therefore, to temporize with the case by aspiration, or without it, in the hope that nature may effect a spontaneous evacuation either externally or through a bronchial tube, is to leave the majority of patients to die an almost certain death. Listerism and the use of the drainage tube have put into our hands a safe method of treating large abscess cavities by small openings, and it would be to our eternal disgrace if we did not avail ourselves of it.

The propriety of the operation offers, therefore, little ground for difference of opinion, for when we come to the detail of its performance we find that there are some points which have been, and still are, disputed. The principal of these is the question of the advantage or disadvantage of resection of ribs. This point in the operation has been advocated on two grounds, viz.:—

1st. To allow room for the insertion of a

proper sized drainage tube, and to prevent subsequent compression of the tube.

2nd. To allow the collapse of the chest wall—which is said to be a part of the process of repair in the obliteration of the cavity—to take place the more readily.

On the first point I may say, that in the cases of which I have here read the notes, it would have been impossible to insert between the ribs any but the smallest drainage tube, so that the principle of drainage could only be efficiently carried out by some such plan as those which I adopted; and I believe that in children generally, and in some adults, similar conditions of the intercostal spaces obtain with similar indications for treatment.

On the second point it has been questioned whether any collapse at all of the chest wall takes place, or, at any rate, remains permanently in the average case.

I am inclined to think that in most cases, at any rate, a certain amount of collapse of the chest wall does take place after the operation, but becomes later on more or less completely obliterated again as the lung expands to resume its original dimensions. And this brings us to the most interesting question which was asked by Dr. Shewen at one of the meetings of this branch last session, as to what are the forces by which—against the pressure of the atmosphere within the thoracic cavity—the lung, an elastic organ, is enabled to expand so as to occupy again the space originally taken up by it. No satisfactory explanation of this fact has yet, I believe, been offered, but that such expansion does take place there can be no question. And if, as Dr. Shewen demonstrated, this expansion of the lung can take place as well without any removal of ribs, it is certainly a needless injury and risk to the patient, and therefore unjustifiable. But there are a certain number of cases in persons beyond what is called young adult life in whom this expansion of the lung fails, and in whom the cavity remains unclosed for very lengthy periods. It was for the relief of such a case that Roser first operated with resection of ribs in 1859. Dr. Simon, in 1869, was the first to lay stress upon the resection for the purpose of allowing the chest wall to retract. Very extensive reactions have been performed successfully by Estlander, (*Archiv. f. Klin. Chir.*, 1881) who recommends the removal of parts of from 3 to 7 ribs. With the same object Schneider has removed a portion of the clavicle as well as of several ribs, and Schede has removed the other tissues of the chest wall with the thickened costal pleura, so that the skin was brought into contact with and allowed to adhere to the pulmonary pleura.

That in patients of this class the obliteration of the cavity takes place by collapse of the chest wall in addition to expansion of the lung within, is, I think, established, and should guide the treatment in these cases.

In the two cases before us to-night my primary and principal object in resecting portions of rib were, as I have already stated, to make room for a drainage tube of sufficient size to be introduced, and to prevent its compression in any collapse of the wall which might follow. The result has been all that I could desire; the length of time which elapsed from the operation to the complete closure of the cavity was, in each case, little more than six weeks, and the present condition of the left lung in the patient who is shown to-night is most satisfactory.

Surgery is a science and an art, or, as I think it might be better expressed, the practice of an art which is dependent upon and correlative with a science. The art so called—that is, the pictorial art—has had many fluctuations in the history of the world, and even in this nineteenth century has hardly recovered the position which it held amongst the Greeks. But it is not so with our art—the art of surgery; whatever fluctuations it has been subject to have had but little influence upon its general progress. It would be a reproach if the practice of our art did not make great strides in these days, when the knowledge of those facts of anatomy and physiology, upon which it is based, have advanced so wondrously. And in no department of surgery have greater steps in advance been made than in the treatment of diseases of the cavities of the body. What would our grandfathers have thought of a proposal to open and drain the peritoneal cavity, or to remove a tumour from the actual substance of the brain itself? And yet the former of these operations is boldly and confidently undertaken by men who have followed in the footsteps of Spencer Wells, while the latter has actually been performed, and may be considered as an operation of the future.

The surgery of the thorax can be considered as second in importance only to that of the abdomen, and its future is great and ensured. The treatment of phthisical cavities of the lung by external opening and drainage has already commenced. The treatment of gangrene of the lung and of new growths within the thorax—connected not only with the lungs but with the other most important viscera contained in that cavity—offers new fields for the development of the resources of our art, which cannot fail to add greatly to its honour, and to contribute to that great and noble object which it always has in view—the alleviation of human suffering and the prolongation of human life.

NOTES ON TWO CASES OF STRANGULATED HERNIA, WITH GANGRENOUS GUT.

By JAMES GRAHAM, M.A., M.B., RESIDENT MEDICAL OFFICER PRINCE ALFRED HOSPITAL, SYDNEY.

M. R., æt. 56, admitted on the 3rd March, 1885, with a strangulated umbilical hernia, and placed under the care of Dr. Fortescue.

She was a strong, healthy, corpulent woman. An irreducible umbilical hernia showed itself in the form of a large pedunculated mass, measuring twenty inches in circumference. It was first noticed seven years ago, following what the patient called a strain, from lifting a heavy weight. She had not hitherto regarded it as sufficiently serious as to lead her to seek timely advice, either for relief or cure, so that it was allowed to hang as it grew, until its pressing discomfort caused her to improvise a truss of calico bandage.

The symptoms of strangulation had existed for four days, and reduction by the process of Taxis had been freely tried before her admission into the hospital. The area of strangulation was tense and tender, the pain great, and the vomiting distressing but not fæcal. Temperature 102.6, and the pulse 98.

Dr. Fortescue made an incision about two inches long into the upper surface of the neck of the hernia. The sac was opened, and the stricture relieved. The strangulated portion of the gut looked suspiciously purple, but as it was thought that the chances were in its favour, the wound was brought loosely together, and dressed with Ung. Iodoform and Salicylic wool.

The temperature immediately fell, and the pulse lost its distressed character.

For two days following the operation the patient experienced great discomfort from rapidly increasing tympanitis, colicky pain and vomiting.

On the 6th March, Dr. Fortescue re-opened the wound, and found that the bowel broke down at the seat of the old stricture on the slightest touch. This he stitched to the edges of the original incision. A large quantity of flatus and of grumous inflammatory fluid immediately passed through the fistula thus formed. On the following day fæces oozed through the opening, the Tenax covering with which it was dressed forming an admirable deodorising receptacle.

Her progress now became uninterrupted. On the 22nd March she had a good evacuation by the natural passage. Tepid water injections were given every alternate day, to prevent any attempt

at straining, and the rest thus afforded led to the rapid healing of the fistula.

She left the hospital on the 27th April in good health, with the abdominal wound closed.

A. C., æt. 40, admitted on the night of the 22nd April, 1885, with a strangulated femoral hernia on the right side, and placed under the care of Dr. Goode.

She was a delicate looking woman, the mother of a large family, and two months pregnant at the time of her admission.

The hernia had existed for six years—was the size of a small lemon; up to a few months ago was easily returned, from which time it had become irreducible. It had never given her the slightest trouble, nor had she understood its true nature, until she sought relief for her symptoms of strangulation.

Taxis had been tried before her removal to the hospital. Before admission, and after the attempted reduction, the patient stated that the bowels had acted, and that the swelling, she imagined, was smaller and less tender.

On examination, the abdomen was not distended, but slightly sore on pressure; the tumour itself was not tense, and pressure gave but little pain. The vomiting was occasional, but not alarming; there was nothing unusual either in her pulse or temperature.

23rd.—Ice had continuously been applied throughout the night, and morphia given in the form of suppositories. Sickness was neither distressing nor excessive; and her temperature and pulse seemed consistent with the apparent fact that she had been relieved.

24th.—Abdomen became slightly tympanitic. Slight sickness still present, and troublesome heartburn.

Dr. Goode cut down on the swelling. On freeing the sac from its adhesions, he found there was no room to pass even the edge of the nail through the stricture. After dividing the stricture, and opening the sac, the bowels were found to be quite gangrenous, without any break in its continuity. After snipping the gangrenous portion, he stitched it at its healthy part to the edges of the incision.

25th.—Temperature, 99.6; pulse, 108; thirst; heartburn; slight distension of abdomen; no pain, and no discharge through the fistula.

26th.—Temperature, 100; pulse, 100. No sickness; free discharge.

27th.—Sickness quite stopped; abdomen flacid; large quantity of fæces passed through the wound.

28th.—Patient had passed a good night, but in the forenoon was suddenly seized with severe

abdominal pain; tympanitis rapidly increased; pulse rose to 160; patient got into a collapsed state and died at 5.30 p.m.

The post mortem examination showed that some intestinal contents had got into the abdominal cavity, through a part which had sloughed after the operation, and that the dreaded peritonitis had brought about the fatal issue.

REMARKS.—Writers so frequently represent the fatality of the operation for strangulated hernia, that notes of the above successful case seemed, in consequence, worthy of record. Authorities insist on the importance of surgeons resting contented with relieving the stricture, and cutting down only on the neck of the hernia, opening the body of the sac almost always proving fatal. The patient was kept lying on her side, which, with her naturally pendulous abdomen, favoured drainage to the uttermost.

The case of femoral hernia is interesting, as showing a series of symptoms of apparent reduction following Taxis, justifying delay in operating, and yet a condition of gangrene of the bowel being found on cutting down.

ANEURISM (?) OF ŒSOPHAGUS— PROFUSE HÆMORRHAGE—LIGA- TURE OF COMMON CAROTID— RECOVERY.

BY WILLIAM S. BYRNE, M.B., BRISBANE.

EDMUND COTTRELL, aged 30 years, unmarried, no history of any specific disorder, was always well up to the beginning of 1883, when he had an attack of quinsy which lasted about a week. About twelve months after this he had what he describes as a "catching in the throat," which was accompanied by the expectoration of a large quantity of mucus, which affected his breathing to a certain extent, and from this he suffered for about three weeks, when, on walking home from his work as a compositor one night, he spat up a large quantity of blood. He, himself, describes the amount as "mouthfuls." No medical aid was available, and shortly after arriving home the bleeding ceased. He was seen by a medical man next day, who prescribed sulphurous acid spray. The "catching" in his throat gradually passed off, but the throat continued irritable and he continued to spit up mucus in large quantities. He was never troubled with any cough, and had not lost any flesh. There was no difficulty in breathing, nor in deglutition; no soreness nor pain. Thus he continued for twelve months, when

he consulted me for slight blood spitting, which had occurred during the week. On examination of his chest there was nothing abnormal to be discovered. Apparently the lungs and heart were perfectly healthy. The left tonsil was slightly enlarged, and on laryngoscopic examination nothing more was discovered, except a little congestion of the vocal cords. He spat up, in my presence, a good deal of mucus tinged and streaked with blood. I prescribed ice to be sucked, a gargle of perchloride of iron, and ergot internally, but the bleeding gradually became worse. A long list of remedies were gone through during the next three weeks, painting the œsophagus with perchloride of iron, hypodermic injections of ergotin, etc., etc., but the patient became steadily worse, bleeding as much as an ounce or two ounces three and four times a day. Dr. Little, of this city, met me in consultation, and we decided to wait events for the present, having again carefully examined the chest and throat with the laryngoscope without discovering anything to account for the hæmorrhage. The next night the patient spat up eight ounces of pure blood, and, after consulting, we decided to ligature the common carotid on the left side. Accordingly, next morning, the patient having been prepared for chloroform, the anæsthetic was administered by Dr. E. H. Byrne, and with the valuable assistance of Dr. Little I tied the common carotid artery just above the omo-hyoid. The further progress of the case was most satisfactory. There was no hæmorrhage from the throat after the operation, and the patient made a good recovery. For some days he complained of dimness of vision on the affected side and headache, but this gradually passed away as the collateral circulation was established. The ligature did not come out till the fifty-second day, which is remarkable.

REMARKS.—Considerable anxiety was felt by Dr. Little and myself when recommending the operation—Firstly, because there were no *certain* signs of the hæmorrhage proceeding from the œsophagus, or even the side affected. Secondly, the large mortality from the operation for hæmorrhage. In the eighth edition of "Erichsen's Surgery" is stated, "Harrison Cripps has collected fifty cases of ligature of the common trunk (carotid) for hæmorrhage, twenty-eight of which terminated fatally." One sign I have omitted to mention. When a brush was passed down the œsophagus, small clots of blood were brought back adhering to the hair. It is now two months since the ligature was applied, there has not been a sign of blood, the patient has recovered his usual health and strength, and is gaining flesh daily, so I may conclude that the operation in this case was successful.

AMELIORATION OF THE DEATH-RATE OF SYDNEY AND ITS SUBURBS FROM PREVENTABLE DISEASES.

By J. ASHBURTON THOMPSON.

At the time that Dr. MacLaurin read his paper on the prevalence of typhoid fever in New South Wales before the Medical section of the Royal Society I was absent in Melbourne. I have, however, read certain reports of it, and I find myself obliged to differ from him and from some of the gentlemen who joined in the discussion upon it in some important particulars, as well as from Prof. Anderson Stuart, whose paper on the disposal of typhoid excreta by cremation was published in the *Gazette* for May. I venture to offer the following statement of my views for consideration. The figures are taken from the last published report of the Registrar-General, that, namely, for 1883.

PROPOSITION I.

That filth diseases other than typhoid killed more people than typhoid killed.

1883.

Deaths from Diarrhoea and Cholera.	Deaths from other zymotics except Typhoid.	Total zymotic deaths except Typhoid.	Deaths from Typhoid and Infantile Fevers.
402	253	655	170

PROPOSITION 2.

That the suburbs are less healthy than the city.

1883.

District.	Death-rate.	Deaths under 5 to total deaths per cent.	Zymotic deaths under 5 to total deaths per cent.	Total deaths under 5 per 1000 living.
Sydney...	19.30	42.09	7.74	8.12
Suburbs..	26.08	53.59	12.78	10.76

PROPOSITION 3.

That no other cause for the greater unhealthiness of the suburbs can be surmised than worse methods of drainage and scavenging there than in the city.

NOTE.—“In the districts which suffer the high diarrhoeal death-rates, the population either breathes or drinks a large amount of putrefying animal refuse. A certain quantity of diarrhoea depends no doubt on other causes than putrefactive pollution of the system. Phthisis * * * temporary faults of diet * * * habitually improper food (especially in the case of infants and very young children) and various other influences contribute to the total of diarrhoeal deaths. * * * The fullest allowance for those causes cannot sensibly affect the general conclusion I have stated above.” Simon: Report to the General Board of Health on the preventability of certain kinds of premature death. See also Dr. Greenhow's paper on the different proportions of death produced by certain diseases in different districts of England, on which the above remarks are based. It will be observed that whatever (other

than the putrefactive pollution of air and water) contributes to increase the deaths from diarrhoeal diseases here must at least operate evenly, but probably operates to a less extent in the suburbs than in the city, yet, that the death rate from that class of disease is higher in the suburbs.

PROPOSITION 4.

That it is illogical to propose that special measures should be taken against a particular filth disease in the face of the figures shown under Proposition I.

PROPOSITION 5.

That in the absence of any sanitary organisation, and for want of the laws which would be necessary, it is not possible to take special measures against the particular filth-disease, typhoid fever.

PROPOSITION 6.

That measures taken against filth-diseases in general, would of necessity be effective against typhoid fever, which differs (if it do differ) from the others in a respect which is not of distinctive importance in the present case.

PROPOSITION 7.

That the money saved by preventing filth-diseases would much more than repay the cost of preventing them.

DATA.—Deaths from fever, 170; estimated death-rate, 10 per cent. Deaths from other diseases in Order I. of Class I., 583; estimated death-rate, 7 per cent. Average value of each life, both sexes, all ages, £106 (Dr. Farre's estimate for England); estimated cost of each case of not-fatal illness, £4. Then—

170 deaths from fever, at £106 ...	£18,020
1,530 cases of illness from fever, at £4 ...	6,120
655 deaths from other zymotics, at £106 ...	69,430
9,857 cases of illness from other zymotics, at £4 ...	37,428

Total money-loss by preventable disease, for the single year, 1883 ... £130,998

NOTE.—No account is taken here of deaths of children from pulmonary inflammations, or of the deaths registered as from dentition or convulsions, although the relation between their prevalence and a prevalence of the zymotics is well known. All those deaths, too, which result from not fatal attacks of the zymotics, and at last come to be registered under different heads, are of necessity left out, as well as some indirect causes of money loss.

In conclusion, I beg leave to express this opinion: That to procure real progress in sanitation, enlightenment is more effectual than compulsion; but nothing of great practical importance can be done until we have Local Government, either towards sanitary teaching or the practical prevention of these diseases. Much, doubtless, might be done by popular lectures on Hygiene,

and much more by the earnest endeavour of each of us to instruct his patients day by day from the faults observable in their own dwellings; but best of all, probably, would be the effect of appointing Medical Officers of Health. Their work would be done under the eyes of the people, who would soon learn how to watch for the result of their labours, and thus a practical interest in sanitation would be awakened. It is true that at present the public take no interest whatever in this subject, which, nevertheless, vitally affects them. This, in all probability, is due to want of knowledge, not of the science, but of the results already and long since achieved by it—a knowledge which to-day is almost common in England. But this explanation, of course, cannot apply to our rulers; they must be better instructed, and yet they make no sign. Should our first step, then, not be to procure the introduction of a Local Government Bill? And are we not, as a profession, in the very best position to urge this measure personally upon those whose duty it will be to carry it through?

NOTES OF A CASE OF DIABETES MELLITUS.

UNDER THE CARE OF CRAIG DIXSON, M.D. ET CH.M., ED.; F.R.C.S., ED.; HONORARY SURGEON (LATE HON. PHYSICIAN) TO THE SYDNEY HOSPITAL.

REPORTED BY WILLIAM H. COUTIE, M.B. ET CH.B., MELB., PETERSHAM, NEAR SYDNEY; LATE RESIDENT MEDICAL OFFICER AT THE SYDNEY AND MELBOURNE HOSPITALS, &C.

D. T., æt. 33, married, by occupation a plasterer, was admitted into the Sydney Hospital on March 7th, 1883.

He stated that he had been ill since the previous November, when he began to suffer from continual thirst, as well as general pains, most severely felt in the head, back, and joints of the arms and legs. He soon became wearied on the least exertion, and then noticed his eyesight failing. He complained of passing a large quantity of urine, and also of frequent micturition, at one time so bad that he states that he passed water every eight or ten minutes—this, however, did not continue long.

The skin became dry and harsh, and abdominal pains frequent, sometimes accompanied with vomiting.

The bowels were irregular, the motions at times very dark and lumpy, and there was a good deal of tenesmus. The thirst increased and the appetite became somewhat voracious, but he became thinner and weaker, and sometimes passed, he states, about 30 pints of urine in 24 hours.

On admission the patient was very thin and wasted, skin dry and harsh, appetite capricious, tongue dry, bowels constipated. There was dimness of sight, great thirst, and he passed large quantities of urine containing sugar—specific gravity, 1037.

March 8th.—Temperature, 98.4; weight, 8st. 12½ lbs. Ordered codeia, gr. ½, in pill, every six hours, and nitrogenous diet. The codeia to be gradually increased.

March 19th.—Temperature has been normal since admission, except on the morning of the 11th, when it rose to 99.6. Is now taking iv grains of codeia every six hours.

Average quantity of urine passed:

During the first three days, 819 oz.

„ second „ 288 oz.

„ third „ 267 oz.

March 21st.—Is improving. Skin now soft and moist; tongue red and clean; appetite somewhat improved; bowels inclined to be costive. Weight, 8st. 10½ lbs.

March 28th.—Continues to improve, but complains of having little sleep. Has not the wasted appearance he had on admission; appetite variable; he still suffers from thirst; skin soft and moist. Passed 216 oz. of urine yesterday.

Is now taking v grains of codeia every six hours.

March 30th.—Complaining of headache and pains in both legs; bowels confined. To take aperient medicine.

The codeia increased to vi grains every six hours.

April 2nd.—Tongue coated; appetite poor; is complaining of abdominal pains and flatulence.

R. Liq. Bismuthi	3i
Sp. Amm. Co.	℥xx
Sp. Chloroformi	3ss
Acid Hydrocyan. dil.	℥iij
Aq. Carui	3i

every four hours.

April 3rd.—Easier this morning. To take vii grains of codeia every six hours.

April 11th.—Is getting stronger and in better condition. Weight yesterday, 9st. 11b. Temperature continues normal. Has slight abdominal pains.

April 12th.—Passed 190 oz. of urine yesterday.

April 15th.—Passed 182 oz. of urine yesterday.

April 17th.—Passed 158 oz. of urine yesterday. Weight, 8st. 8lbs.; has headache; tongue clean, red; bowels confined.

Pulv. Scammon. Co. gr. xiii. p.r.n.

Is now taking ix grains of codeia every six hours.

April 24th.—Passed 140 oz. of urine yesterday.

Is taking x grains of codeia every six hours.

April 25th.—Passed 160 oz. yesterday. Com-

plains of epigastric pains and flatulence; bowels constipated; tongue red and somewhat glazed; skin drier than usual; dozes during the day, but does not sleep well at night; has slight scalding pain on voiding urine.

R. Magnes. Carb.	gr. xx
Spt. Ammon. Co.	℥xxx
Aq. Men. Pip.	℥i p.r.n.
Pulv. Scamm. Co.	gr. xx s.s.

May 15th.—To take xii grains of codeia every six hours; urine continues to decrease in quantity, passed only 116 oz. yesterday; appetite poor; thirst great; slight shooting pains about the back and legs; eyesight appears to be getting worse.

May 28rd.—To take 18½ grains of codeia every six hours. Passed 138 oz. of urine yesterday.

June 2nd.—To take xv grains of codeia every six hours. Passed 128 oz. yesterday.

June 6th.—To take xii grains of codeia with iodoform gr. ¼ every six hours. The codeia to be decreased, and the iodoform increased, gradually.

June 12th.—Is now taking ix grains of codeia with 1 grain iodoform every six hours.

June 13th.—Urine continues to decrease in quantity, passed 113 oz. yesterday. Complains of nausea and headache.

June 14th.—To take 1½ grains of codeia with 1 grain of iodoform every four hours.

June 15th.—Was restless last night; has gastric pains this morning; tongue red and dry.

June 16th.—Very restless; headache; abdominal pains; no appetite; has been vomiting.

Bismuth mixture ordered, and brandy 4 oz.

June 17th.—Was delirious last night, and is very restless this morning; is complaining of severe lumbar pain; cannot take much nourishment. No vomiting this morning. Brandy to be continued.

June 18th.—Very delirious; continually tossing himself about.

June 19th.—Much worse; cannot take any nourishment. 6 p.m., patient died.

REMARKS BY DR. CRAIG DIXSON.

This case is interesting, instructive, and important for the following reasons:—

1st.—That it was a well-developed case of the disease, the patient having suffered for about three months before admission, and was very much wasted and in a serious condition.

2nd.—It shows the remarkable influence of codeia in controlling the disease. Up to a certain dose the patient filled out, became more cheerful and happy, with a moist skin; in fact, general improvement resulted up to the giving of 12 grs. every 6 hours. The urine fell from 380 oz. on the 9th March to 102 upon the 19th May, while the sp. gr., which was 1037 on admission,

fell to 1030. The increase from 12 to 15 grs. of codeia every 6 hours resulted in no further benefit. I then determined to try iodoform.

3rd.—The case proves that we shall have to accept the encomiums which have been passed on this latter drug by certain continental physicians with caution, as our patient almost at once lost ground after commencing it, although he took some codeia with it, as I wished to only gradually reduce this drug for obvious reasons.

I gave iodoform for ten days, during which time the doses given were gr. ¼, ½, ¾, i. every six hours.

I was then compelled to leave it off, as the patient's condition became so bad, in fact typhoid, tongue dark brown and dry, with sordes on lips and gums, gastric and abdominal pains, vomiting, &c.

It was evident that nothing was to be obtained from the iodoform, as its influence seemed only to be pernicious. I therefore stopped it on the 16th, and ordered alcohol with ¼ dose of solution of hydrobromic acid every four hours, with of course such suitable diet as he could take, but all to no purpose, as our patient gradually sank, and expired on the 19th, three months and twelve days from time of admission.

I most certainly think that the patient was so bad on admission that it would have been next to impossible for him to have survived more than a fortnight without proper treatment, and I attribute any improvement in his condition to the large doses of codeia.

I am sorry to say a P.M. could not be obtained, owing to the objection of the friends.

ASSOCIATION INTELLIGENCE.

SOUTH AUSTRALIAN BRANCH.

MONTHLY MEETING.

Held at the Adelaide Hospital, April 30th, 1885.

Dr. C. Gosse (President) in the Chair.

Dr. Altmann was present as a visitor.

Mr. Walpole was elected a member of the Branch, and Prof. Watson and Mr. William Robertson were elected members of the British Medical Association and of its S. A. Branch.

A letter was read from Mr. Elliott, of Yorke Town, in which he drew attention to the fact that a chemist lately from Adelaide had set up as a general practitioner in his district, and without being registered or possessing any medical qualification, had placed a plate on his door styling himself "Surgeon and Accoucheur." Also that a woman, formerly a nurse, had commenced practice as a medical woman at Edithburgh, and signed death certificates which were accepted by the district registrar. He had drawn the attention of the Chief Secretary to the facts of the case, and four months after received a reply to the effect "that there is nothing to prevent the person referred to practising in the manner mentioned." In conclusion, he urged the necessity for

there being a suitable Medical Act, and said that such existed in the other colonies, where they were not inoperative.

Dr. ALTMANN, at the request of the President, then gave some particulars respecting the want of medical knowledge of a man called Klostermann, who had recently been connected with the death of Mr. Doppel, which had been made the subject of an inquest. He had no hesitation in saying that Klostermann could not have studied at the University of Posen, because such a medical school did not exist; and that he had not passed the Staats Examination at Berlin was evident from his gross ignorance of medical matters. As he (Klostermann) had asserted on his oath that he had those qualifications, would it not be possible to prosecute him for perjury?

After several members had discussed the question, a resolution was unanimously carried, "That the President (Dr. C. Gosse), Dr. Cockburn, M.P., Dr. Stirling, M.P., and Mr. Cleland, should form a committee to investigate the whole matter, and take such action as seemed most desirable and practicable."

At the suggestion of the President it was resolved to inform the Chief Secretary "That the medical services of the Association would be placed at the disposal of the Government, should such be required in the event of hostilities arising with any of Her Majesty's enemies."

Prof. Watson then made the following observations on some osteological specimens.

REMARKS ON SOME SPECIMENS OF BONES.

By PROF. WATSON, M.D., F.R.C.S.E.

The specimens which I have the honour of showing to the Society this evening form part of an osteological collection presented to me by my friend Dr. Gosse, and are of both pathological and anthropological interest.

I. The first is the skull of an aboriginal who had evidently attained mid-adult life when his career was abruptly cut short by a somewhat triangular, non-radiating half-a-crown sized pond-fracture of his left parietal eminence, probably "the last of many scars," as Dr. Gosse informs me he was known to the earlier colonists as a warrior of very depredatory proclivities. In this case the inner, more brittle, or vitreous table, is less extensively involved than the outer and more elastic one, which forms also part of the segment of a greater circle. This apparent paradox, Dr. Gosse explains as the result of direct violence on living bone by a peculiar form of native club, in which the striking end is expanded laterally into a beak-like process. The pentagonal form of the cranium is but an exaggeration of what is usually seen in the Australian. I look upon the presence in this particular case of a fronto-temporal suture as accidental rather than racial, being met with as such more often among the natives of some of the more northern islands of the New Hebrides; in the gorilla and chimpanzee always replacing the ordinary speno-parietal suture of man. Worth notice are also the narrowness of the lower jaw, the thickness of basilar part of its body, smoothness of the masseteric surface of its rami, and absence of an osseous landmark for facial artery.

II. The next specimen is the skull of an aged European, in which, although there is no unilateral obliteration of lambdoid suture, there exists, nevertheless, a

very great asymmetry of occipital region which possibly resulted from a wryneck (combined or not with rickets) during life. I cannot inform you as to whether its owner was or was not during life an epileptic.

III. The third specimen is the base of a weatherworn skull (probably European, and like the preceding one somewhat asymmetrical). In addition to total absence of part of groove for left lateral sinus (which in this case terminates at point of exit of a well-marked mastoid foramen or emissary vein), and an associated diminutive jugular fossa (giving free exit nevertheless to a large inferior petrosal sinus), it presents a very perfect unilateral atlo-occipital synostosis, with some displacement forwards of lateral mass of atlas on same (left) side. As regards the etiology of the latter, it is probably analogous to some of those cases of bony ankylosis of the temporo-maxillary articulation, described by Heath as resulting from some mild form of bye-gone septic arthritis incident on one of the exanthemata of childhood (scarlatina, &c.) ignored or forgotten by patient. Possibly, however, it is the outcome, not of a local manifestation of a general infection as above, but of local injury, or even of invasion by continuity from neighbouring diseased or injured parts. Although probably congenital, the close proximity of the atlo-occipital articulation suggests a possible pathological solution to the abnormal condition of jugular fossa, &c. Inasmuch as a perversion of nutrition of the coats of jugular vein at its cranial exit, caused by the combined pressure of periarticular (at same time perivascular) inflammatory exudation, and the displaced lateral mass of atlas, plus a slowing of blood-current from same causes, would suffice for production of a clot which, extending into lateral sinus, and having in present case neither undergone a fatal disintegration nor yet a fortunate absorption, afterwards bore its share in a general shrinking and fibroid substitution of occluded part of blood-sinus, followed "*pari passu*" by a purposive osseous obliteration of that part of groove for lateral sinus overlying the jugular process of occipital.

IV.—The fourth specimen is the overgrown left tibia of an adult aboriginal. In comparing it with its fellow of opposite side, one sees that it is not only circumferentially enlarged, but that it is more than an inch longer than the other, presenting in addition an exaggerated curve forwards. The morbid change probably commenced in it as a local manifestation of (possibly hereditary) syphilis during youth, and by the addition of an unnatural stimulus to the physiological one already existing in developmental cartilage, gave rise to the extra lengthening, which periostitis, *per se* (while accounting for the thickening), cannot explain. In young people such cases are at times difficult to distinguish at first sight from central or ossifying peripheral sarcomata, of which latter our hospital museum possesses a splendid example put up by Dr. Verco, amputation of the limb above the next joint, in absence of a "diagnosis by remedy," having more than once been the lamentable result. The disease of the second (right) tibia being limited to one single osteo-periostitic node of shaft, probably ulterior in its onset to that of other side, and consequently at a time when shaft had more nearly reached its adult length, had caused a fusiform thickening, but no undue lengthening. Dr. Stirling informs us that a recent explorer in South America has discovered syphilitic bones in the tombs of the Incas of ancient Peru. In the present instance the diseased bones, although from an old native burying ground, probably do not reach further back into antiquity than the civilizing influences of our immediate forefathers would account for.

VICTORIAN BRANCH.
ORDINARY MONTHLY MEETING.
Melbourne, Wednesday, 20th May.

The President, Mr. J. T. Rudall, F.R.C.S., Eng., in the chair.

NEW MEMBERS.

THE Honorary Secretary announced the election, as members of the Branch, of Mr. T. S. Ralph, of Kew, and Dr. Fleming, of Stawell.

CORRESPONDENCE.

The correspondence included a communication from the President and Secretary of the Colonial and Indian Exhibition, inviting contributions from the Branch. The Honorary Secretary was instructed to collect, so far as the circumstances permitted, whatever would be likely to be of interest relating to the profession in the colony.

Dr. T. S. Ralph, President of the Microscopical Society of Victoria, then read a paper entitled:—*"Micro-Chemical Observations on the Blood in Health and in Typhoid Fever,"* which will be published in our next issue, as a coloured plate, to accompany the paper, could not be completed in time for the present issue.

In the discussion which followed the paper, the remarks of the speakers had reference principally to the inquiry of how far the appearances described by the author were due to the effect of the reagents upon the chemical constituents of the blood, or upon its organic contents. It was suggested, for example, that perhaps the ether of the solution of hydrogen peroxide, acting on the fatty principle, might explain some of the appearances.

MR. RALPH, in reply, said that his investigations had been conducted with an especial wish to reach the element of bacteria, and judging by his experiments, it would appear that some of these were completely acted on, and some only partially. He wished to see if he could link this fact to outside practice. The question of a possible development of bacteria from protoplasmic substances possessed the highest interest, and also in a narrower sense their decomposition into fluid and gaseous bodies. Bacteria certainly developed putrefaction, and it was quite as certain that bacteria were an effect of the putrefactive process.

CRIMINAL LUNATICS.

DR. GRAHAM drew the attention of the meeting to a recommendation of the Lunacy Commissioners in their last progress report, to erect a building for the reception and treatment of criminal lunatics in the Sunbury Asylum Reserve. He remarked that about five years ago the Council of the Association had paid a visit of inspection to the Kew and Yarra Bend Asylums, and had found the institutions crowded to such an extent that the lives of the inmates were in danger from the want of a sufficient quantity of pure air to support health. They were packed together like sardines in a tin, whilst their day-rooms were turned into dormitories, and the recreation hall was filled with beds, some of the patients being obliged to sleep in earth-closets; and in one ward containing only 10,861 cubic feet, were huddled together 75 inmates, leaving only 144.8 cubic feet for each inmate. That matters were not better now might be gathered from the report of the Lunacy Commission, which stated that there were, at the present time, 100 persons in asylum buildings more than they were calculated to accommodate. The cubic space recognised by the English Lunacy Commissioners as the lowest compatible with health, was for single dormitories 770 cubic feet, and for associated dormitories 550. It was therefore apparent that the urgent requirements for increased buildings could no longer be delayed without seriously injuring the health of the inmates already confined therein.

On the 31st December, 1868, there remained in the Public Asylums of the colony 1556 inmates, and on the 31st December, 1883, the number remaining were 3193, an increase in 16 years of 1637, equal to an annual increase of 103.5; the population of the colony at the former period being 674,000, and at the latter 931,000, the increase being 257,000. Assuming the general population to increase in the same proportion during the next 16 years, we might reasonably calculate that 2000 additional insane persons would require housing and care, and so we come to the question as to how this accommodation should be obtained. The experiment of boarding out harmless lunatics had, in nearly every country in which it had been tried (except Scotland), been attended with disastrous results. England, Ireland and America, and the Isle of Man had all been unsuccessful. In the latter island, Dr. Outerson Wood informed the *British Medical Journal*, that boarding out was formerly the only way of providing for the insane; but ill-treatment, neglect, and other grave abuses had existed to such an extent, that the Legislature had been obliged to provide asylum accommodation for the insane poor. The class with whom lodging and care were found for the pauper lunatics in Scotland did not exist here, and it might safely be predicted that the boarding out from our asylums would not give much relief to the engorged condition of these institutions.

The recommendation, therefore, of the Lunacy Commission, to erect on the Sunbury Asylum Reserve a separate institution for the custody of 200 criminal lunatics, would not relieve the pressure for more than a year, as there were now 100 to begin with, and as it would require 12 months to build and furnish the new asylum, the increase of next year would fill it up, and matters would be as bad as ever. He thought the Commission had given this subject very little consideration. If they had quoted fairly, instead of manipulating the figures at their disposal, they would have seen that an asylum capable of holding from 500 to 600 patients should be commenced without delay in some country district on a line of railway, with at least two or three thousand acres of land, to enable the patients to occupy their time in farming, gardening, and husbandry generally, such occupation being now looked upon as the best agent in promoting cures in asylums for the insane.

But he desired to say further, that there were grave objections to housing criminal lunatics practically under the same roof with ordinary insane patients. Criminal lunatics were a class wholly apart from other lunatics, and should therefore be entirely separate, not only as to the building containing them, but as to their superintendence and treatment. He therefore submitted the following resolution:—

"That this Association, whilst approving of the recommendation of the Lunacy Commission, to provide separate accommodation for criminal lunatics, protests against the erection of an asylum for this class on any reserve attached to, or connected with, existing institutions for the care and treatment of the non-criminal insane. And this Association would point out that the criminal asylums at Broadmoor in England, Dundrum in Ireland, Perth in Scotland, and the State Criminal Asylum at Auburn, near New York, are all unconnected with non-criminal institutions, the two latter being in connection with prisons. And, further, this Association recommends that the Premier of Victoria be requested to place a sum on the estimates for the purpose of erecting in the country, with the least possible delay, an asylum capable of accommodating between five and six hundred inmates; such institution to have at least 2000 acres of land attached to it, in order to employ the inmates at farm-work, which is one of the best agents

of cure. Such asylum should be near a railway, within easy access to Melbourne, say Lilydale, Dandenong or Frankston."

Some discussion took place upon this motion, and it was eventually agreed that in consequence of the importance of the subject, its further consideration be postponed until the next meeting.

Some new surgical instruments were exhibited by Messrs. Mayer, Meltzer and Jackson, and the members then adjourned to the Maison Dorée for supper.

NEW SOUTH WALES BRANCH.

The 49th General Meeting of the Branch was held in the Royal Society's Rooms, Sydney, on Friday, 8th May, at 8.15 p.m., Dr. Knaggs, Vice-President, in the chair.

Dr. D. COLLINGWOOD read a paper on Two Cases of Empyema (see p. 209).

The patient (a boy of 6 years) was exhibited and examined by the members.

Dr. SCOT-SKIRVING complimented Dr. Collingwood upon his admirable paper, and certainly no better results could have been produced by any other method than that which had been so ably described. However, as Dr. Collingwood had opened up the whole question of the treatment of collections of pus in the thoracic cavity, he would like to make some observations upon that subject. He submitted that cases operated upon early, the elasticity of thoracic contents would enable them to expand, so that there would arise no need for the walls to contract. If, however, the case be an old one, and adhesions take place, then there would be a necessity for resection. Now, regarding the opening, attention should be paid to the principal surgical axiom: free exit of pus and a dependent opening. This should be as far back and as low as possible. In order to attain that, he quoted two instances in which he first made a small opening above, say about region of lower angle of the scapula or in the axilla, then a small probe, such as is used for diagnosis, inserted as a director, and from the inside projected against the integuments, to act as a guide upon which to cut down upon at the lowest part of the cavity. This lower opening would possess two advantages—allow free drainage while the patient remained in a comfortable recumbent posture. As to the difficulty Dr. Collingwood referred to—the close approximation of the ribs—that would be always encountered in young subjects when the perforation would be attempted in the front of the thorax, but never were the operation to be performed at the posterior aspect—near the articular end of the ribs—where the interval between them is wider. Moreover, if much contraction, mechanical contrivances could be arranged to meet this difficulty, such as tracheotomy tubes or catheters, which could be covered by means of the india-rubber drainage tube. He believed irrigation should not be used more than once or twice, and ought to be discontinued when discharge ceases, then the cavity would clean itself. He agreed with Dr. Collingwood as to thorough antiseptic treatment, especially as used by Lister, and with his precautions, which no doubt shortens the treatment, and possibly this helped Dr. Collingwood in his cases of resection of ribs; thus the sinus remained longer open, and freely open, so that there was no obstruction to a free discharge, and in this respect Dr. Collingwood's success must have been partly due to the resection.

Dr. DIXON could not, in his experience, remember any cases which surpassed Dr. Collingwood's in brief duration of course of time occupied by treatment and cure, but he had not had much experience of this

operation in children. In adults, he quoted a case in which he opened the chest and drained it well, and he obtained good results in about three months. No one could dispute the advantages of free drainage as found in these cases. He believed he had lost time when he had aspirated, and in one instance when he had withdrawn by that means 80 ounces of pus, it rapidly reaccumulated, but the subsequent free evacuation with perfect drainage helped the patient over his trouble in about twelve weeks. He, however, quoted cases under Lister, Billroth and others where even cases with free drainage and Listerian precautions became chronic, and extended from 15 months to 7 years where resection did not check the discharge. Young cases were always good subjects if healthy. Dr. Collingwood's first case was very unpromising, being an unhealthy subject, with bad family history, and existing under bad hygienic conditions. Agreed with Dr. Skirving against resection as being always difficult of performance.

Dr. HANKINS believed the element of success to be perfect drainage. In his last three cases he adopted the method described by Dr. Scot-Skirving for making a counter opening at the lowest point of the cavity, using a uterine sound as a probe. In adults he had always sufficient room, and resection was not required. It was different in children, where he saw the trouble which would be caused by the ribs compressing the drainage tube and blocking the discharge. He instanced the case of a young woman whose ribs were very closely approximated so much as to compress the ordinary rubber tubes. Here he, by means of hot water, softened and then flattened a vulcanite tracheotomy tube, which he used with satisfactory results.

Dr. KNAGGS, while approving of resection in such cases as quoted by Dr. Collingwood, thought that no hard and fast rule should be laid down, but that each case of empyema should be treated upon its merits. In several cases of empyema in young children, which he had treated by free drainage and antiseptic irrigation, he had not met with the difficulty produced by the close approximation of the ribs. No doubt this was because he generally operated posteriorly—near the articular ends of the ribs. He had also had flattened tubes constructed which could fit between the ribs without producing much irritation. He was a firm believer in free exit and frequent antiseptic irrigation, and in some instances made two openings.

Dr. COLLINGWOOD, in reply, stated that, from experiments on the cadaver, Wagner had shown that in the recumbent posture fluids escaped freely from the thorax through an opening situated in the sixth or even fifth interspace, and close to the outer edge of the latissimus muscle. His objection to openings placed more posteriorly was the inconvenience in dressing and the pain caused the patient when lying on his back, whereas by the plan he adopted all manipulations, until the dressing itself was changed, could be performed without moving the patient from the recumbent posture. His experience differed from Dr. Skirving's in the matter of rigid tubes which he had seen used but abandoned on account of the irritation and pain produced. He thought, too, that it would be difficult to irrigate at the time of the operation because the chest could not be, and was not so far as he had seen, emptied before the second or third dressing. Moreover, such solutions as carbolic acid would tend to coagulate the pus, and so to increase the flakiness of the contents, which is one difficulty in emptying the cavity at first. With regard to the method of passing a tube in at one opening and out at another, as adopted by Dr. Hankins, he thought the objection that such a tube would necessarily remain *in situ* until nearly the close of the case, carried considerable weight.

THE fiftieth general meeting of the New South Wales Branch was held on June 5 in the Royal Society's Rooms—Dr. W.W. J. O'Reilly, president, in the chair. The minutes of the previous meeting having been read and confirmed, Dr. Creed, as honorary secretary, reported to the meeting the death of Drs. Fortescue and George Renwick, late members of the New South Wales Branch, and, by the wish of the meeting, moved—"That the president, Dr. O'Reilly, be requested to write letters of condolence to the families of these two gentlemen, expressing the deep regret and sympathy of the Society with them in their irreparable loss; and also that the meeting be adjourned until this day week, as a token of respect to their memory." Dr. Quaife, the late president, seconded the motion in most feeling terms, and it was unanimously carried.

REPORTS OF SOCIETIES.

MEDICAL SECTION OF THE ROYAL SOCIETY OF NEW SOUTH WALES.

A GENERAL MEETING of the Medical Section was held at the Royal Society's rooms, Elizabeth-street, Sydney, on Friday evening, 16th May. Dr. Mackellar presided, and there was a large number of members present.

Dr. Kendall read a paper on *Milky Hydrocele*, which will appear in our next issue.

Then followed a paper entitled:—

SOME CONSIDERATIONS ON THE PREVENTION OF TYPHOID FEVER.

BY HENRY N. MACLAURIN, M.D.

"I purpose to bring before you this evening some considerations connected with the prevention of typhoid fever, and with what I conceive to be the duty of the Government in that regard. The importance of the subject will be readily gathered from the following facts, which I am enabled to lay before you in a systematic form by the kindness of Mr. Sager, secretary of the Board of Health. I have also to thank the Registrar-General for his courtesy in providing us with the statistics for 1884, which are not yet published. From the tables which I hold in my hand, it would seem that in the last ten years there have died of typhoid fever in the city and suburbs no fewer than 1,357 persons; giving an average of about 136 deaths per annum. In the country districts for the same period the deaths amounted to 2,287, giving an average of, say, 229 per annum; average total, 365 per annum. Nor do these figures represent, by any means, the whole of the evil. It would seem that in the hospitals the average death-rate of this disease is about 15 per cent. of the cases affected. But in the hospitals there is what may be called an adverse selection, most of those admitted being severe cases. Hence, I think, we may infer that for the whole mass of cases the death-rate is somewhat lower; say 10 per cent. We find, then, that in Sydney and its suburbs during the last ten years there have been about 14,000 cases of terrible, though preventable, disease, bringing the gravest anxiety and distress, and in one-tenth of the cases causing death, with its attendant misery and grief. And the patients who suffer from typhoid are for the most part in early youth, or in the full vigour of life, precisely at that period at which the prospect of life and usefulness should be greatest. For the country districts the amount is 2,287 deaths, with about 23,000 cases, thus giving a total for the colony of 3,644 deaths, and about 37,000 cases, in ten years. If all these people were to lose their lives, or to receive serious

wounds in a war, the public attention would be forcibly arrested by it, but as they die from really preventable causes, operating in an unseen way, in our midst, at all times, not much thought seems to be taken for it. I say operating at all times, for, while typhoid is at some times more virulent than at others, I am in a position to state that during the last ten years there has not been a single month in which deaths from typhoid fever have not taken place in Sydney or the suburbs. By a return from the hospitals (Sydney Hospital, Prince Alfred and Coast Hospitals) I find that in last year there were 754 cases admitted, with 102 deaths. In four months of this year there have been 335 cases, with 50 deaths. This would at first sight look as if the disease were becoming more prevalent and more virulent; but we must remember that we have passed through the four months of this year in which typhoid generally rages most severely. On the whole I cannot say, from an examination of the table, that the disease is steadily increasing in gravity; for, while it is now much more prevalent and more deadly than in 1880 and 1881, it is certainly not much worse than it was in 1876 and 1878, when it proved very fatal both in Sydney and in the country. Why fever should be more prevalent in some years than in others it is not easy to say. Probably the difference depends on certain unknown conditions, which influence the development of the virulence of the *materies morbi* after its ejection from the body of the patient. Pattenkofer's speculations as to the influence of subsoil water are well known. Into this subject I do not, however, propose at present to enter; it is sufficient for me just now to show that typhoid fever prevails to a most alarming extent, and that it assumes the gravity of a real plague. How is this plague to be stayed? What action are we to take in the face of a disease which makes so deadly an attack on the strength and vigour of the nation? Such is the question to which I wish to direct your attention this evening. It is not necessary to enter on the consideration of the point whether typhoid fever can arise spontaneously. It is possible that, in some unexplained way, some unusual ferment may arise in decaying excrementitious matter, which, when opportunity is given, may produce in a healthy human being the phenomena of typhoid fever; but practically this mode of origin can be left out of count. We may safely take it for granted that in the vast majority of instances, in temperate regions at least, every case of typhoid arises by communication of a *materies morbi* from a previously existing case; further, that the *materies morbi* is, generally speaking, originally contained in the alvine excretions; and that, after being expelled from the body, if allowed to find its way to an appropriate nidus, it will increase greatly in virulence. Its origin is within the body of a sick person; its development into a more deadly virus often takes place after its ejection. I shall assume these propositions as granted; to bring forward the facts on which they are founded would occupy too much of your time, and would be unnecessary before such an audience. Clearly, then, if we wish to arrest the epidemic spread of the disease, our most effectual plan will be by the thorough and systematic destruction of the *materies morbi* as soon as possible after its exit from the body of the patient. This object has at no time been lost sight of by the profession in our dealing with cases of this disease. As is well known, we are most particular in insisting upon a disinfection of all dejections and evacuations from persons sick of typhoid fever. But every one knows the difficulty, and in many cases the impossibility of carrying it out effectively. Of this it is not necessary to give examples. For even if disinfection by so-called antiseptic solutions be carried out

with the utmost possible care and thoroughness, we cannot feel perfect confidence in its success. The only absolutely certain disinfectant, as was clearly stated to the section the other evening by Professor Stuart, is fire. Destruction by fire, thoroughly and carefully carried out, is the only means by which we can certainly get rid of the *materies morbi* of typhoid fever. But the technical difficulties incident to the thorough combustion of alvine dejections, without the production of offensive gases, are so many that the process is practically impossible in private dwellings, and can be carried out only in furnaces specially arranged for the purpose. Hence I propose that the Government should undertake the matter as a branch of the service of public health; and I am strongly of opinion that if it be carried out with the same vigour and determination which were shown in the case of small-pox, we shall find in a very few months that typhoid fever, if not altogether suppressed, will have become a comparatively rare and sporadic disease. With this view it will be necessary first of all that there should be passed an Act for the compulsory reporting of cases of infectious disease, and more especially of typhoid fever. In this matter the Government would be in a high degree dependent on the goodwill and assistance of the medical profession, but from the well-known public spirit and devotedness of medical men, these may, I think, be safely counted on. So, when any case of typhoid showed itself, a report should at once be made to some such authority as the Board of Health, who should then be brought into communication with the medical man attending the case. Under his superintendence, by the instrumentality of the officers of the board, all action should be taken which is requisite for the public health in the matter. Thus, in many cases, the patients might be removed to suitable fever hospitals, where they should be treated under the most favourable circumstances, and where special care should be taken that they were no longer a source of danger to the community. In case of fever breaking out in dairies, steps should be at once taken to prevent its dissemination by the milk supply, while a thorough investigation by a builder or surveyor would show whether there were any danger of water contamination. With respect to those patients who elected to remain in their own dwellings, pains should be taken to carry out the removal and destruction, by fire, of all infectious evacuations, and the thorough disinfection by heat, or even, if necessary, the destruction at the public expense of articles of bedding or clothing which were stained with infective material. A little consideration will show how readily the details of this plan could be carried out. Vessels could be provided in which the infectious matters could be preserved with some temporary disinfectant for the very short time which should elapse before the next periodical removal to the cremating furnace. A delay of a few hours would be of no great moment, and it is difficult to see how, with any energy in management, a longer delay should take place. There is an apparatus at the quarantine establishment called the Frazer disinfecting apparatus, part of which might serve as a model for the means of transport of clothing and alvine dejections from the patients' houses to the crematory furnace. It consists of an iron cart, in which the offensive material could be transported without the least risk of any evil consequences resulting. This cart can be moved directly into the furnace if necessary. As for the furnace employed for the destruction of infectious matters, there are many models which would answer perfectly well. I hold in my hand a sketch plan of the cremation furnace now actually in use at Milan. Something of this style

would be quite sufficient for the purpose, and I have no doubt that the professional advisers of the Government in the department of engineering would very soon find out the proper combination of economy and efficiency. Of these furnaces there ought, in a town like Sydney, to be several, the number being regulated by convenience, and by the locality of the cases of disease. In small towns one furnace might suffice. In country places, from the sparseness of the population, the absolute destruction of foetid gases might not be quite so necessary as in cities, and furnaces of a less expensive character might possibly be sufficient.

In this short paper I have endeavoured rather to throw out a suggestion than to work out a plan in detail. You will see, sir, that my proposal is twofold. 1st. That the Government should have a right to immediate information of the occurrence of any case of infectious disease, more especially of typhoid fever, which is perhaps the most easily arrested of all. 2nd. That, having received this information, the Government should provide private persons with that assistance in the way of disinfection which it is practically impossible that any householder, however anxious to do his best, can provide for himself. By this plan the flow of infection all over the land would be stopped, as it were, at the fountain head, and we might fairly hope that the fatal disease would soon become almost extinct. It is true that the expense would be considerable. Fever hospitals cannot be kept up for nothing, and cremation is necessarily attended with expense. But even from the point of view of pounds, shillings and pence, I think we should find it a notable saving to preserve the lives and the health of the thousands of persons who are annually attacked by this disease."

Considerable discussion ensued.

It was pointed out that typhoid was less prevalent in dry weather than during wet.

Dr. KNAGGS hoped that the matter would not pass over without full discussion, as it opened up a most important field for inquiry. Personally he was a very strong opponent of a medical man being compelled to notify the nature of a patient's disease to the authorities and thereby appearing to act the part which might lead him to be looked on as a spy by his patients. While removing excreta in the cart proposed there would always be the risk of disease spreading. He had every faith in a thorough and proper disinfecting scheme, and the passing of a Health Act, with the appointment of special medical officers. By this means, he maintained, the disease could be effectually stamped out.

Dr. ORAM thought that as long as our present wretched municipal arrangements existed, so long must we expect to have typhoid fever amongst us. He had had some experience of the sanitary officers representing the Sydney Corporation, and felt bound to say that they exhibited a most deplorable amount of ignorance and incapacity. (Hear, hear.) He agreed with Dr. Knaggs that the sooner we had a proper Health Act the better. So long as our suburbs continued to be cut up and subdivided as at present, just so long would typhoid remain amongst us. The sooner, also, we got rid of our wretched system of privies (a perfect eyesore to the suburbs) the better.

Dr. FOREMAN pointed out that other cities had got rid of typhoid entirely (notably Vienna) without recourse to cremation. Everything might be accomplished by proper drainage and pure water.

Dr. GOODE admitted that disinfectants were efficacious if thoroughly carried out; but one great difficulty was in getting one's directions properly

carried out by nurses. He referred to the danger arising from germs from dejecta being passed into sewers. He saw nothing insuperable in the cremation process, although the expense would be large. It would be quite easy to have a sealed vessel in a house and remove excreta daily.

DR. KENDALL held that the great turning point in connection with the typhoid epidemic was the insanitary condition of the city. He advocated the formation by Government of an official hospital in the city, wherein skilled nurses could be trained. He saw nothing impracticable in having the fæces conveyed away from houses and cremated.

DR. HURST pointed out that it was little use giving us a water or a sewage scheme if the pipes were still to be laid side by side, as the percolations of sewage impurities were sucked up into the water mains, and the germs of disease widely sown. If that were obviated, he thought that the typhoid epidemic would be greatly diminished.

DR. O'REILLY contended that the deposit of fæcal matter on our watershed should immediately be stopped. He suggested that, under the present urgent situation, iron tanks, after the style of hop-tanks, could be utilised—constructed so as to fit on wheels, and to be towed to sea in silt barges.

The CHAIRMAN also took part in the discussion. He stated that the excreta of typhoid patients disseminated disease, and that this reached the human body by means of infected water or milk being imbibed. Disease might reach human bodies in other ways, but it certainly did in this way. Recently he had received from a clergyman at Randwick a letter requesting him to do something in the case of a woman there who was suffering from fever, and some of whose family had also suffered. It appeared that the well from which was taken the water the woman had drunk was situated only two yards from a closet, and was, in fact, at a lower level. It was quite true that the dry earth system was used at the place, but in all probability portions of fæcal matter from patients were left about, and he had no doubt were washed into the well. He also pointed out how quickly milk became infected with typhoid germs, and he referred to the instance of the Government having closed a dairy last year because the milk in it was infected. Apropos of the disposal of fæcal matter, and the possibility of the dissemination of disease by water, he would like to mention one or two other circumstances that came under his notice. On the previous night he had stopped several men who were proceeding through the town with night carts, and entering into a conversation with them he learned that they were about to take large quantities of nightsoil to a reserve portion of Moore Park, behind Mount Rennie and Mount Steel, where already they had deposited a very large quantity of the same material. On the following day he visited the locality, and found there several large trenches into which hundreds of loads of fæcal matter had been deposited, and in which indeed large quantities were continually being placed. Workmen, he noticed, were engaged in covering the deposits with sand. The positions of the trenches were in several hollows on the western slope of a sand ridge which divided the Lachlan Stream from Shea's Creek, and therefore the visible flow was not towards the watershed but towards the creek he had mentioned. He paced the distance from the nearest filth trench to the crest of the ridge which bounded the Lachlan watershed, and found that it was only 38 paces. This trench in its

highest part, he would say, was about ten feet below the ridge on its western side, so that it would be impossible for water to flow directly from it into the watershed. As, however, all fluid matter when poured on sand descended beneath the surface, he could not say that the contour of the land offered an accurate indication of the course such fluid water would eventually take, and in his opinion it was quite as likely that the moisture would filter eastward as westward, that was to say towards the Lachlan Stream as well as towards Shea's Creek. He was not certain that the circumstances he had related had any very potent effect as to the cause of typhoid fever here, for had the fæcal matter which he had referred to obtained direct access to the watershed it would in all likelihood have decimated the whole city. It appeared to him, however, to be a barbarous idea to deposit so large a quantity of fæcal accumulations, as well as the whole garbage of a city of a quarter of a million of people, in what must be acknowledged to be, at any rate, close proximity to their water supply. Probably their great safeguard in this matter had been the fact that dry sand contained a large amount of air amongst its particles, and therefore the organic filth was readily oxidised in passing to the lower strata, but when the sand became thoroughly saturated with rain the air was of course driven out, and the organic matter passed easily through to a very great distance without material alteration. The whole matter was one which, in his opinion, should engage the most serious attention of the authorities. Although the cremation of typhoid fæces was a desirable thing, and would certainly have a material tendency to diminish the virulence of the disease, it must be used as an adjunct and accessory to other means still very important, the principal of which was the bringing into operation of a Public Health Act. Such a measure as this, he thought, would probably be passed through their Legislature at an early period, and would, he supposed, follow the English Public Health Act. This Act contained clauses making it penal for persons suffering from infectious fever to enter public conveyances without first informing the owners of the fact, and it also contained clauses for punishing owners of vehicles for carrying persons so infected, unless they immediately afterwards disinfected their vehicles. Other clauses made it a misdemeanour for landlords to let houses in which infectious disease had recently existed without first cleansing and disinfecting such houses, and informing incoming tenants that disease had recently existed therein. If such a measure as a comprehensive Health Act were passed here, and they had in addition a plentiful and pure water supply, and an efficient system of drainage, he had little doubt that typhoid fever would rapidly disappear from amongst them.

DR. MACLAURIN replied to the arguments, and the proceedings closed.

DR. MACLAURIN submitted the following statistical return showing the number of deaths from diarrhoea, dysentery, and typhoid in the colony for the past nine years:—1875: Diarrhoea, 596; dysentery, 214; typhoid, 298. 1876: Diarrhoea, 459; dysentery, 162; typhoid, 401. 1877: Diarrhoea, 586; dysentery, 162; typhoid, 375. 1878: Diarrhoea, 633; dysentery, 227; typhoid, 441. 1879: Diarrhoea, 496; dysentery, 193; typhoid, 265. 1880: Diarrhoea, 483; dysentery, 174; typhoid, 238. 1881: Diarrhoea, 611; dysentery, 153; typhoid, 266. 1882: Diarrhoea, 826; dysentery, 162; typhoid, 450. 1883: Diarrhoea, 670; dysentery, 100; typhoid, 397.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, JUNE 15, 1885.

EDITORIALS.

THE TRANSFER OF MEDICAL PRACTICES AND ITS DANGERS.

At the Supreme Court, New Plymouth, on May 6, before Mr. Justice Gillies, Dr. Alexander, of Hawera, applied to the Court for an injunction to restrain Dr. Richards from practising within 80 miles of Hawera. It appears that a year ago Dr. Richards sold his practice at Hawera to Dr. Alexander for the sum of £70, Dr. Richards agreeing not to practice at Hawera, or he would forfeit and pay £800 as damages. Dr. Richards recommenced practising at Hawera, and the present proceeding was brought against him. Counsel having advanced arguments *pro* and *con*, his Honor said that although the numerous authorities quoted by Mr. Samuel for the plaintiff went strongly to support his contention, he did not agree with the decisions; and as it was a matter in which he could use discretionary powers, he would not grant the injunction.

The above case is one of several which have occurred during the last few years in these colonies. With the increased numbers of practitioners and the greater value of practices when transferred from one practitioner to another, which this increase of medical men creates, it is probable there may others occur from time to time. The general ruling of the courts of Australasia is, that it is contrary to the public well-being to forbid any man from following his calling when and where he pleases, and so any undertaking not to practice is illegal and of no effect, except so far as it depends on the honour of the transferrer, and this, we are proud to say, is nearly always sufficient as regards the medical profession. Neither is a sum of money to be forfeited as a penalty of effect, for no private individual has the power to inflict a penalty which can only be inflicted by a court of justice. The agreement to be binding should provide that in

the event of the transferrer practising in a given district he shall pay a certain sum of money to the transferee as liquidated damages, consequent on such practice. This sum of money is recoverable in a court of law as a debt, and thus, and thus only, can a medico purchasing a practice be duly protected. Most of these disagreeables may be avoided by arranging the transfer of practices through an agent who makes it his specialty, and who, in this particular line, is often a better adviser than the average lawyer. We can only tender our sympathy to Dr. Alexander in his hard case, and hope that public opinion will so express itself as to render the injury to his practice by the return of Dr. Richards to the district which he was in honour, if not in law, bound to avoid, a mere nothing. As to Dr. Richards, we can only regret that he, as a member of our profession, should have been guilty of such gross disregard for his word and bond, and can but hope that all we could say in condemnation of his conduct in this instance he in his conscience feels.

A LATE CONVICTION OF A CHEMIST IN FIJI FOR ILLEGAL PRACTICE.

In the *Sydney Morning Herald* of April 4 last, a somewhat sensational paragraph appeared, giving an account of a case which occurred in a police court in Fiji. It stated that a chemist's assistant had been fined £2 for having sold a customer a mixture for dysentery from which his wife was suffering. The ordinance under which this fine was inflicted is one regulating the practice of medicine in Fiji. The paragraph went on to say that in the town where this occurred there were two chemists but no medical practitioner, and implying that great tyranny was exercised in punishing the defendant, who was only attempting to relieve suffering in the absence of a properly qualified practitioner of medicine. Feeling that the case could not be as published by our morning contemporary, but that it must have been grossly misinformed as to the facts of this case, we wrote to the authorities in Fiji, requesting an explanation. This has been sent to us by the direction of His Honor the Administrator of the Government. And we find the real facts of the case to have been as follows. In Suva, where the case occurred, so far from there being no doctor, there are four duly qualified medical practitioners, two of whom are in constant and regular practice, the others, though not in practice, but occupying high official positions, would, on emergency, attend to a case requiring treatment. There are also two chemists in the town duly licensed as such under the same ordinance, both of whom had been in the habit of prescribing medicines, and,

though frequently warned, persistently continued to do so; this practice, it had been shown, not being conducive to the public well-being. The particular case for which one of them was convicted and punished was that of a coolie woman, the medicine being supplied to the husband, a coloured immigrant under the protection of the Government of the colony. We need hardly point out to our readers the serious risk to life, which a patient suffering from dysentery in a tropical climate, must run when her treatment is attempted by a mere stripling such as this chemist is, without training in medicine, physiology, or pathology, and with the superficial knowledge of *materia medica* which the trade of a chemist requires, and consequently how really called for was the prosecution instituted by the authorities, when the subject of treatment was a person from her position and colour especially under their protection. The facts as published purported to have been extracted from a local paper, but they were apparently wilfully distorted when first published. Had there been no medical practitioner available, the conduct of the chemist might have been justifiable, but with two medical men always, and two others on emergency, available, we cannot but think the venturesome and aspiring chemist deservedly punished.

A TEMPERANCE HOSPITAL PROPOSED FOR MELBOURNE.

It has been proposed by Dr. Rose, M.P., and others in Melbourne, to establish a temperance hospital, in which patients may be treated without the use of alcohol, except as a drug. We hardly see the necessity for such a special institution, for in a well conducted hospital this is really what is done at present by all medical officers who exercise a careful and judicious supervision over their patients. No doubt, in many instances, unnecessary quantities of liquors are ordered by some practitioners, but carelessness, or mistaken and peccant good nature in this particular is becoming rarer each day. To attempt to treat the whole of the patients admitted to a general hospital without alcoholic drinks would be fatal to a large number of the cases, and we think all patients are in a better position to be cured when under the care of practitioners having no strongly marked prejudices either for or against alcohol than in a hospital the very principle of its existence being a prejudice of its officers against a valuable, though often abused, means of cure. We are certain that no conscientious abstainer has ever had alcohol forced on him against his will in the treatment of his case, except when it was used really as a drug.

DEPOSITION OF NIGHT-SOIL IN DANGEROUS PROXIMITY TO THE SYDNEY WATERSHED.

AGAIN the chronic carelessness and neglect of the Sydney Corporation in sanitary matters has come to light, through the vigilance of the Principal Medical Officer, Dr. Mackellar, to whose knowledge it came that the night-soil removed by the contractors in the employ of the Corporation was deposited in such a situation as to render the contamination by it of the water supply not only very probable, but almost a certainty, when the porous nature of the sandy soil of the watershed is taken into consideration. The Municipal Council, so far from expressing gratitude to him for the eminent service rendered to the inhabitants of Sydney by his discovery, are so ungrateful as to grumble at him for doing as he did, saying that there were other matters known to the Corporation of far greater danger to the public health, which he had better have enquired into. If this is so, is it not their duty to send him full particulars, that he may point out to the public, their masters, their greater sins?

"OH THAT MINE ALDERMAN WOULD WRITE A BOOK!"

THE promptitude with which the City Council ordered that the night-soil of Sydney should no longer be shot on the same area from which the water-supply is derived, as soon as public attention was drawn to their practice by the Medical Adviser to the Government, is not reassuring. It warrants the inference that the Council's conscientious care for decency and the public health is not so great but that these matters would probably be better encouraged if their supervision were entrusted to any other body. It will be remembered that when the Wood-paving Board warned the Government that under certain circumstances danger might arise from an extensive use of that kind of roadway, the caution was ridiculed by the Corporation and the lay press, although it was admitted that the Board was competent for the duties entrusted to it, and had spared neither pains nor time to form a just judgment. This contradiction may have been found a little puzzling by some people; but, after all, what is considered harmful and what harmless depends upon the knowledge, and, we must now add, the taste possessed by him who delivers the opinion. From this point of view some light is thrown upon the criticism referred to, by the following quotation from the first of a series of letters by Alderman John Young upon the report of that Board, which were published in the columns of a morning contemporary at the time:—

"I think the Board must be credited with having raised a scare and with frightening people by the sensational announcement of the discovery of a new kind of bacteria * * * on similar grounds might the Board report against the use of any more water from the Botany watershed because organisms of some kind are found in it; and they might reply that water also to be perfect must be pure, although perfectly pure water is unattainable."

It appears from this extract (now that we know exactly what kind of unspeakable contamination the City Council has gratuitously given to the Botany water quite as well as the Council should have known it all along) that Alderman John Young's notions of what may be considered purity in air and water differ considerably from those of most other people. A gentleman who, with the other members of the body to which he belongs, does not consider an admixture of ordure with their (and our) drinking water either disgusting or dangerous, cannot be reasonably expected, perhaps, to regard the admittedly remote dangers which under special circumstances might arise from wood-paving. The quotation also gives us an opportunity to congratulate another morning contemporary upon the shrewdness which led it to insert the following remark in its leading columns: "If Mr. McClure had had to deal with half-a-dozen men of the world, or sharp witted aldermen, he would have talked yellow fever in vain." Without allowing the same weight to Mr. McClure's evidence, we hasten to say that we now for the first time see how extremely probable it is that our contemporary was right in this conjecture.

Apart from badinage, however, this outrage—we may almost say this unparalleled outrage—upon the decency and the common sense of the community affords a very strong ground for demanding that matters affecting the public health be placed under the supreme control of a central authority, and no longer left to the criminal carelessness or the ignorance of the City Council.

QUACKERY IN SOUTH AUSTRALIA.

WE see by the report of the last meeting of the South Australian Branch of the B. M. Association, that the same evils, with regard to the practices of unqualified and uneducated persons, exist in that colony as they do in New South Wales, but we can hardly imagine to so great a degree. We think the Association has acted wisely in appointing a committee from its members to enquire into the matter, and to take such action as may be deemed advisable to mitigate the evil. As two members of this com-

mittee are members of Parliament, it is possible that they may be able to bring such pressure to bear on the South Australian Government as will do something to lessen if not to quite do away with this serious public evil, one which, though annoying to the profession, is of vastly more importance to the general public, who are in their ignorance preyed on by these charlatans.

THE OPENING SPEECH OF HIS HONOR THE ADMINISTRATOR OF THE FIJIAN GOVERNMENT, DR. W. MCGREGOR, C.M.G., AT THE ANNUAL MEETING OF CHIEFS HELD AT TAVUKI, KADAVU, ON MAY 4, 1885.

WE heartily congratulate the colony of Fiji on its good fortune as exhibited in the appointment by the Imperial Government of His Honor, William McGregor, M.D., C.M.G., &c., &c., as Administrator of the Government of that colony since the departure of Sir William des Vœux. We reprint that portion of the English translation of the opening speech, delivered by him in the Fijian language, at the annual meeting of chiefs held at Tavuki, Kadavu, on May 4, 1885, which relates to sanitary matters; its perusal will make manifest how much to the advantage of the native population it is, that members of our profession should be chosen as governors of new colonies containing a large native population, or where the health of the people, white or coloured, is suffering from defective sanitary arrangements, capable of improvement. It will be seen that His Honor's remarks are eminently practical, and such as could only come with good effect at first hand, and not nearly to so good purpose as the advice of a medical officer filtered through a lay governor. The decrease of the population during last year, consequent on an epidemic of whooping cough, though not nearly so great as that caused by measles a few years since, is yet of a very serious nature, and proves how essential strict quarantine is for the protection of an aboriginal population. The remarks as to the houses are practical and wise, and the careful consideration for native usage in the respect due to the chiefs in this matter is most praiseworthy, and exhibits the careful thought displayed by Dr. McGregor on native affairs. The advice given with regard to the native food supply cannot help doing good, and it is by recommendations such as these that we may hope to see the evils consequent on deficient food reduced to a minimum. The training of native youths for the practice of medicine amongst their countrymen is the result solely of Dr. McGregor's action, and shows practical good sense and true philanthropy in its con-

ception and execution, and is but one of the many examples of the paternal care exercised by the British Government in its treatment of its native subjects in all its dependencies.

We now reprint the portion of the Opening Speech referred to above :—

"I have now to direct your attention to a matter of extreme importance that has caused me much sorrow and regret.

"I am pained to tell you that, during the year ending September last, there was a large decrease in the number of the people, there being actually 2,562 more deaths than births. You, chiefs, will see at once how serious this matter is, and you will not wonder when I tell you that I consider it of infinitely greater importance than anything else you can discuss at this council. Do not the Government and the chiefs exist only for the good of the people? You, Rokos, are the deputies of the Governor: your duties are to be as a father to your people, to lead them, to teach them, to feed them; and the Queen will hold her Governor and you responsible for their welfare. It is therefore our duty to find out why the people have decreased in numbers, and when we have discovered the reasons, then we must secure and apply the remedy.

"The principal, if not the sole, immediate cause of the great decrease of last year was an epidemic of whooping cough. This is an insidious disease which we cannot keep out of Fiji. True, we have kept out small-pox and cholera by detaining people and ships in quarantine for a long time. But I must tell you that measles and whooping cough cannot be kept away from you. Fortunately, measles and whooping cough rarely attack the same person more than once. Moreover, if towns are clean, houses good, and the people in comfortable circumstances, measles and whooping cough do not often cause many deaths in other countries.

"In time to come there will be a great many more deaths from dysentery than from measles and whooping cough. Probably few will die of the two last diseases in future. You know that mortality is heavy here without the presence of any new epidemic disease; but the same causes, you must remember, that occasion this heavy mortality in ordinary years, greatly increase the number of deaths from any epidemic disease.

"Now, what are these causes? This question you have discussed in each council, but not with that earnestness which the extreme importance of the subject demands. The time for indifference is past.

"I believe the people are dying from these causes:—1st, bad houses; 2nd, insufficient food; 3rd, uncleanness of towns and bad water; 4th, neglect of women, children, and the sick.

"With regard to bad houses. Lately I have been inside several thousands of the houses of the people, and I can tell you what are their chief faults. In many of the newer towns the foundations of the houses are not sufficiently raised; in a great number it is even with or below the level of the surrounding ground. Who can lie on a cold, damp floor without becoming sick?

"Now, as an excuse which, from what I have noticed in the older towns, I have not been able to accept, many of the common people have said to me, 'We cannot have raised foundations to our houses, for it would be disagreeable to our chiefs; in the old days it would, perhaps, have brought the club on our heads.'

"Respect to chiefs and authority is a good thing, and must be maintained in the land, or much evil will arise; but raising the foundations of the houses of the common people would increase their respect for the chiefs, were it made a rule that the houses of no commoner should be

built on a foundation less than one foot high, while the foundations of the houses of the chiefs should be as much higher as the custom of the land require.

"If this were done, you would remove a very frequent cause of dysentery, colds, fevers, and diseases of the lungs.

"This matter was attended to in many of the old towns, so that in some parts of Fiji it would be nothing new. At other places I find very often that the roof of a house is bad and leaky; or that the sides consist of bare reeds only, without makita or other leaves outside. This is bad.

"Now, as to the second cause: insufficient food. We often hear that there is a scarcity of food in certain districts, but seldom indeed do the chiefs of the land admit that there is any want. The reason of this is that, if the chiefs are diligent and show a good example, there should seldom be any scarcity of food in Fiji. A chief is therefore ashamed to say, 'Food is scarce with us,' for anyone hearing him would exclaim, 'What! has this chief been indolent? Perhaps he limes his head, paints his face, and stalks about, thinking only of himself; or is it that he squabbles with his neighbours about some border town, and lets his people starve?'

"I ask you, chiefs, is it strange that on the poorest soil of Vanua Levu, that of Bua, there is always sufficient food. What one of us does not know the reason?

"A regulation regarding the planting of food is in force; how many chiefs or magistrates can say it is carried out? I have seen with my own eyes in several districts that it is not enforced, and that food is not sufficiently abundant, because you now plant less than formerly and sell more. One, Lau Buli, recently asked aid from the Government, because some of his people were starving. Had he reported to his Roko, the latter could no doubt have procured them assistance from some other district. Perhaps that Buli wished to affront his Roko, or to escape reproof for his own negligence if he applied to him; but such things should not occur in Fiji. In the old times there was hardly ever scarcity of food of good quality.

"You possess one article of food which a great many of you may eat fresh and good all the year round, which is unsurpassed as food for healthy people, and even for those suffering from that common and fatal disease, dysentery. I mean taro, which you Fijians should regard as God's gifts to you. Your fathers knew its value, and cultivated more of it than you do now. True, in some places you cannot grow a great deal of taro; but other districts can grow it in unlimited quantity, and it can always be exchanged for other property or other food. I desire to see taro cultivation greatly increased.

"I come now to the uncleanness of towns. When the town is full of filth and rubbish, the water used by the people is usually bad. Far too little attention is paid to this. How many of you have not forgotten altogether about the regulation as to water supply? None of you would eat a rotten yam, or swallow decaying seaweed from the beach, but thousands of you drink water more poisonous, and are content, careless whether you suffer from dysentery on the morrow. I have been to towns where the water pools stink at the doors of the houses of the people, and have even seen it run into the houses in wet weather.

"If you chiefs do not take care, you will soon have only rats and mud-crabs to rule over in such towns.

"Remember that rotting filth poisons everything in a town—air, water and food—and thus breeds and fosters disease, and favours death. Now, what trouble do some of you chiefs take to improve the conditions of those bad towns. The other day, when in a town with ruinous houses, wet and filthy, I thought to myself, surely the

Roko must have forgotten that this town belongs to him. On making inquiry, I was told he had not been there since some time before the measles. Yet this Roko writes in a report of the Provincial Council: 'My people are disappearing, what will become of us?' What indeed, I ask, will become of people so neglected?

"As to the neglect of women, children, and the sick:—

"In one of your former councils, a Buli, when asked how it was that the population was increasing so fast in his district, replied 'Perhaps it is because no woman is allowed to stir about for three weeks after giving birth to a child, nor until the chief of the town has seen that both mother and child are strong.' How many of you have followed the wise example of Buli Bouboucou in this.

"I most strongly advise you to follow his lead in this matter.

"Some of you say: 'The children of the whites live because they get cow's milk; our children die because we have no cow's milk to give them.' How many Fijians are present here that were brought up on cow's milk? Yet ye are strong men, and so were your fathers, and they and you were brought up on the produce of the land. The truth is that you chiefs were reared by women that were well fed, that were kept comfortable, and had nothing to do except to care for you. But the only food employed was that of the land, the same as had been used by your fathers from time immemorial.

"The keeping and tending of cows is unknown to you Fijians, and is moreover rendered very difficult on account of the nature of your cultivation. I therefore doubt that, for a long time to come, it will succeed with you. But, if a mother has rest, a dry comfortable house, and an abundance of good food, the produce of the land, she can nourish her child herself until it is able to eat.

"The rearing of fowls, and the preparation of arrow-root, articles of great use in case of sickness, is, I find, not attended to as provided in the regulation, and often proper use is not made of such fowls as are available.

"Is it true that some of your people are so selfish that, when they do possess fowls, they sometimes go and sell them, when there are sick people, members of their own mataqale, that would be greatly benefitted by such food? Again, I frequently find a sick person in a house without anyone near to give any assistance. These things must be attended to.

"Also let the chiefs of towns and the Mataqali leaders in the town see that each man plants abundantly on the land allotted to him, and that no man sells food unless the chief of the town is satisfied that it will not bring scarcity on his household.

"On the chief of the town should also rest the responsibility of seeing that the town is kept clean, and that the water supply be good and pure.

"Again, the chief of the town is the only person that can see that women are well treated and children looked after, and the sick provided for and cared for. How could the Buli do so?

"One matter I should mention to you with regard to the treatment of the sick. Some time ago I proposed to the Governor that suitable young men of yourselves should be taught something of medicine. I hoped to be able to teach them myself, but other work has prevented that. I am glad to be able to tell you that eight of them are now studying at the Suva Hospital, and Dr. Corney reports of them that they are good men and diligent, and will soon be useful to you."

LEADING ARTICLE.

ON THE PRESERVATION OF INFANT LIFE.

By THRO. M. KENDALL, B.A., SYDNEY,
L.R.C.S.ED., L.R.C.P., L.M., LATE SENIOR
ASST. SURGEON ST. VINCENT'S HOSPITAL.

THE preservation of human life at all ages, in order that good work may ensue, and that colonies or countries may increase in wealth, must ever be an interesting subject to us all. This is more especially the case in a young colony such as ours, where so great an expense has been incurred in bringing out a suitable population. As our local industries increase, so will the preservation of life and the prevention of disease become more and more a duty incumbent on us all; for, in many ways, the preservation of health lies in our own hands, and we should jealously guard the treasure which has been committed to our care.

The Health Exhibition recently held in London brought about much useful discussion upon the subject of health, and unearthed many defects in our sanitary system.

In his admirable address on the National Value of Public Health, Sir James Paget showed that much valuable time and labour is lost to the country through disease. So great is this loss that the mortality of children under fifteen years alone costs the English nation no less than two millions of pounds annually.

This estimate does not take into consideration the great loss due to the necessity of watching and caring for the suffering children.

Paget's next statement makes this loss worse, "for," says he, "in many ways these disastrous losses might be prevented," and he then proceeds to speak of the disgrace brought upon the nation by the presence of typhoid and other fevers which might be kept away by proper sanitation and cleanliness.

In this fair city of Sydney there are, unhappily, many plague spots, which are very slowly diminishing in number, and which ought to be more rapidly swept away, in order that our annual visitor—typhoid fever—might become to us a total stranger. Of course, as the suburban properties become opened up and built upon, a tide of emigration will set forth from our city, but it is these very places, whither the mass of people will emigrate, that need our earnest attention, should be given a proper sanitary system of drainage, and placed under the supervision of an efficient officer of health.

As there are many causes for the loss of population, so there should be an endeavour on our part to seek out means for the maintenance of health, and for the preservation of life.

During the short period of my practice here, I have been greatly struck with astonishment at the ignorance displayed by young mothers in the management of their offspring. In a great measure I think this ignorance is due to the very early age at which women marry in this colony.

The young mother leans for advice on her own mother, who, having been married at an equally early age, is equally ignorant of the proper management of children.

Such a state of affairs cannot but be prejudicial to the life and health of the child, who either dies early or, growing up as a weakly individual to manhood, marries and begets a weakly race. Here we have a loss to our revenue, for such a man will never be able to exert himself sufficiently to perform his proper proportion of the work of life, and much valuable work and time will be lost in the attendance to the wants of himself and of his weakly descendants. Another source of danger to the health and life of the infant is the small income on which young people marry; for the income being small and the family large necessitates the deprivation of many comforts for the existing children, and in many cases compels the mother to work at a time when she is not fit, and renders her liable to accidents which are fraught with danger to the unborn infant. Some years ago the late Professor Pell read a paper before the Royal Society of New South Wales on Infant Mortality. In that paper the Professor stated that:—

“During the years 1860–1875 the rate of mortality was very high, and I attribute much of this to two causes—1, crime; 2, want of sanitation. It is remarkable that the infant mortality rates for the whole colony should be almost the same as for the most healthy parts of England, and 2 per cent. less if Sydney and the suburbs are excluded. These conclusions seem to point out irresistibly that our climate is peculiarly favourable to early childhood, and it will be strange indeed if it be found to be not equally favourable to maturity and old age.”

In the annexed table, Pell gives the rate of mortality of children in one year out of 10,000 of the same age.

Years.	Country Districts.	Healthy Districts.	Peerage.
	New South Wales.	England.	English.
0	852	1,030	696
1	320	335	163
2	141	217	79
3	91	154	47
4	64	126	49

From this table Professor Pell argued that the condition of the average inhabitant of our bush approached that of the average English peer. “For,” says he, “we see on the one hand what wealth and discretion, with all the appliances of the arts and sciences, can effect in preserving infant life; and on the other the effects of nature, with fresh, wholesome air, and with all the ordinary comforts of civilized life. So far art has the best of it.”

In 1884 Dr. Jamieson, of Melbourne, published the following statistics:—

Rate of Mortality per 1,000.			
1879–80.		1876–80.	
N. S. W.	115	Sydney	170
Victoria ...	120	Melbourne.....	163
South Australia	141		
Queensland	135	Brisbane.....	172

In the Eastern portions of the Colonies.

New South Wales	93
Victoria	99
Queensland	97

All these statistics refer to children.

This rate of mortality is very high considering the nature of our climate, and is, I think, to be attributed to the same causes as those to which the late Professor Pell drew attention, and also to the deplorable state of ignorance, with regard to the management of the sick, that reigns among the mass of the people.

Gratis education in these matters is, I am afraid, of little use. The subject must be thrust continually under people's noses, and there allowed to fester and stink before they will awaken to their duty in life, and stretch forth a hand to preserve the health of the inhabitants of their own land.

If the British nation, from the infant mortality alone, is annually subjected to the great loss of two millions of pounds, are we, in a young colony, prepared to submit to a similar loss in the same ratio to our revenue. Ought we not rather to endeavour, by using all the latest results of the arts and sciences, to prevent, as far as lies in our power, the frequent visitation of our colony by those diseases which are due to bad sanitation?

Should we not thus increase our national wealth? Much might be done in this direction by properly regulated sanitation, by good sanitary laws, and by compelling the people to observe these laws. In order properly to carry out the sanitation of any colony, it is necessary that it should be divided into districts, each presided over by an efficient officer, who in turn should be subordinate to a Board of Health located in the metropolis. To aid these officers it will be necessary to distribute small pamphlets of sanitary

laws, so that all might know the law and obey it. The sanitary officer would have the power of visiting all houses, and would make his report of any deficiency to the Metropolitan Board, who would then take such steps as were necessary for carrying out the law. By such a system our sanitary system would be improved, and that this would be a boon to our infant population, no one will, I think, venture to doubt. Besides the diseases due to want of good sanitation, there are others which are brought amongst us by contagion. The progress of these diseases might be arrested by the careful exhibition of due precaution before they acquire a firm hold upon the community. This source of disease would be greatly diminished by a law which compelled the notification of infectious disease by the householder, and I was glad to see that this law was strongly recommended by the late Sanitary Conference. This notification of infectious disease would enable the authorities to take precautionary measures, so that the contagion would be isolated and not allowed to propagate; it would also discover to them many a nidus of a fell disease festering upon an accommodating soil.

As I have before stated, it is quite possible that marriage at an early age is one source of danger to the health and life of our infant population, for the youth of the mother means also ignorance in the management of her offspring.

To remedy this we can lay down no law, but we might well follow the example set by Brussels, Paris, and some parts of England. At these places every person registering the birth of a child is presented gratis with a small pamphlet on the management of children. Perhaps, in many cases, this practice would be without result, but surely it is worthy of a trial.

Dr. Leach, the rural sanitary authority of Sturminster, England, has carried out this practice for some years, and speaks of its unqualified success. For my own part, I feel certain that such a pamphlet would be a boon to our infant population, prevent the deplorable use of the nostrums of unqualified tricksters, and check the results of the evil advice of presuming midwives.

Another source of danger, which I before mentioned, to our infant population is to be found in the slender income of the parents. For this there is not any remedy, but much might be done by following out the Alsatian law, which prohibits the employment of women at any work whatever six weeks before and six weeks after their delivery. Such a law would ward off much danger from the unborn infant, and would also allow the poor mother to regain her strength before she began anew the battle of life. In addition to this, it would enable the child to obtain a good share of

that nutriment which is its natural right, but of which it would have been deprived had the mother gone to work earlier.

The mother being compelled to work, the unfortunate child is left to the tender care of others, probably a very youthful elder sister, and has his appetite quenched with that most solid mixture called tops and bottoms; the result being, most probably, gradual starvation of the unfortunate infant.

At this point a well managed creche steps in to the aid of the infant, and the mother has the satisfaction of knowing that for a small charge she is able to leave her child where his wants will be properly attended to, and her own place will be as far as possible supplied.

For the effectual preservation of infant life it is necessary that children should feed upon the food provided for them by nature; and, failing this supply, it should be our endeavour to arrange an artificial food as nearly like the original as possible. Artificial feeding is not always a success, and should never be employed unless from some cause the natural supply has failed.

At the siege of Paris, when the general mortality was very high, it was noted that the mortality of infants had decreased 40 per cent.

Again, when the cotton famine compelled the mothers usually employed at the factories to suckle their infants, a like decrease was noted.

In the *Handbuch des Oeffentlichen Gesundheitswesens* of Dr. Eulenburg (vol. ii., parts 1 and 2, page 1172), under the head of Infant Mortality, Dr. Finkelnburg, of Rome, gives the following remarkable statistics:—"In Iceland, where the children are fed artificially the death rate, during the first year of infant life, is 295 per 1000. In Norway, where the mothers nurse their children, the death rate is 180 per 1000 during the first five years of infant life.

In the Faroe Islands, where the natives exist in poverty and snow, the death rate is 86 during the first year, and 120 during the first five years of infant life.

In Norway the rate was $\frac{1}{3}$ per cent. due to digestive causes, while in Paris it was $\frac{1}{4}$.

These facts go to prove that artificial feeding is to be avoided, if possible, and when it becomes necessary we should use every precaution so as to ensure success.

The vessel by means of which the food is conveyed to the child, is usually a bottle, and unless the utmost care and cleanliness is exhibited, this very bottle is a dangerous element in artificial feeding.

According to M. Gueniot artificial feeding of infants is as much entitled to be dubbed an art as medicine itself. "For," says he, "as the appli-

cation of ready made formulæ does not make the physician, so the mere mixing of milk and managing of a bottle does not make an infant's nurse."

Gueniot advocates the use of the bottle, and meets its opponents with the statement, that the bottle is a very good thing, but needs, like everything else, proper management. In favor of the bottle, he draws attention to a tomb raised in Paris, to the memory of Madeline —, who by her devotion, has brought up more than sixty infants by the aid of the bottle.

I have made this slight digression to show the danger accruing to the unfortunate infant, whose mother being compelled to work, is left to the tender mercies of others who upset his unfortunate stomach by feeding him with a sour bottle.

This matter of improper food and unclean vessels is, I think, a further argument in favour of the establishment of a well-managed crèche such as they have in Paris. In England, much has been done to supply this want by the Ladies' Sanitary Association; and in France a Society for the protection of infant life has been established which, in addition to taking care of the infant, also undertakes to teach and train young mothers in the management of their children.

Measures such as those I have stated, would, I feel sure, do much towards preserving the health and lives of our infant population, and also to improve the physique of the future men and women of this our fair colony.

I have endeavoured in this paper to draw attention to a question of great importance. The subject is, I know, well worthy of more exhaustive treatment, but I shall be content if I succeed in rousing public opinion.

THE INSANE POPULATION OF NEW SOUTH WALES.

WE have been favoured by Dr. F. Norton Manning, Inspector-General of the Insane in N. S. Wales, with a copy of his Report on the state and condition of the Hospitals and other Institutions for the Insane, for the year ending December 31st, 1884, which shows that on that date the number of registered insane persons in the colony was 2,524, viz.: 1,552 males, and 972 females; of these, 846 were located at Gladesville, 957 (free) and 57 (criminal) at Parramatta, 273 at Callan Park, 241 at Newcastle, and 150 at the Licensed House for the Insane, Cook's River. The Cooma hospital having been closed during the year, the patients were transferred to Callan Park. The number of registered insane persons on December 31st, 1883, was 2,403, and the increase in numbers during the twelve months was therefore 121—78 males and 43 females. This increase is larger than during any former year.

The large increase during the year 1884 appears to be due first to the increase in the number of admissions, which were 493 as against 476 during the preceding year, and to some falling off in the percentage of recoveries. The increase in the population of the Colony

during the year 1884, as shown by the returns from the Registrar-General's Office, having been 51,819, there has been no increase either in the proportion of insane to the general population, which was 1 in 364 at the close of the year, or in the proportion of admissions to the general population, which was 1 in 1,868 for the year.

During the year, 182 recovered, 28 were relieved, 149 transferred, 4 escaped (and not recaptured), and 181 died. The average number resident during the year was 2,435, and the total number of persons under care was 3,058.

The principal causes of insanity, apparent or assigned, were—Intemperance, 49; Epilepsy, 26; Religious Excitement, 21; Congenital Defect, 20; Parturition, 19; Old Age, 16; Sexual Self-abuse, 15; Brain Disease, 14; Mental Anxiety, 12; Domestic Troubles, 11; Sunstroke, 11; Hereditary Influence, 11.

The principal causes of death during the year, were 23 from pulmonary consumption, 22 from epilepsy, 22 from general paralysis, 22 from general debility, 18 from inflammation of lungs, 13 from chronic brain disease, 11 from inflammation of stomach, 10 from apoplexy, &c., &c. Of the 3,068 persons under care during the year, 819 were born in N. S. Wales, 83 in the other colonies, 759 in England, 153 in Scotland, 894 in Ireland, 77 in Germany, 72 in China, 21 in France, and 190 in other countries.

REVIEW.

NOTES ON THE TREATMENT OF TYPHOID FEVER.

By DUNCAN TURNER, L.R.C.P., LOND., L.R.C.S., EDIN. MELBOURNE: STILLWELL AND Co.

IN a colony like New South Wales where typhoid fever is so prevalent, we are ready to welcome any contribution that may aid us in combating the disease. In this pamphlet, however, we recognise little that is new, as indeed the author states, in introducing his subject, that "he has nothing very new or startling to communicate." The treatment as adopted by Dr. Turner is detailed at length, and a number of useful prescriptions are given.

The author is an uncompromising advocate for the use of quinine, but it is doubtful if such credit is due to it in the reduction of temperature, in small doses, as he believes. That the disease is greatly increased by exercise and travelling is familiar to all, and it often happens that the highest temperature is that recorded at the first visit, and too much credit is given to the influence of drugs in the subsequent fall, the other factors remaining unconsidered.

The writer does not estimate the value of the thermometer in diagnosis and treatment very highly, nor does he the use of the bath; as, judging from his remarks, he usually dispenses with it. He states, however, that the system advocated by Ziemssen meets with his approval, and there is no doubt that this is the best method, as it prevents that reaction and increase of temperature often found after the sudden withdrawal of heat from the body.

The treatment by diet and nursing as forming a most important part of the treatment receives due consideration, but surely it is an oversight that no notice is taken of the troubles arising from an injudicious use of milk during the course of the fever.

The notes were originally read before the Medical Society of Victoria, in introducing the subject for discussion, and will be found to embrace the chief points in the treatment of the disease.

OBITUARY.

GEORGE FORTESCUE, M.B. LOND., M.R.C.S.E.

THE news of the death from typhoid fever of Dr. George Fortescue, one of our most distinguished medical men, who died at his residence on the Parramatta River, near Sydney, on June 1, will be received by the profession, not only of New South Wales, but throughout the colonies, with a sense of personal affliction. In the prime of life, and when in the most robust health, he fell a victim to this terrible disease, while attending a patient some four weeks previously. His more than ordinary vigour and medical skill enabled him to cheerfully combat the malady, and during his illness he was generally hopeful of eventual recovery. The night before his death, however, he suffered a relapse, and gradually succumbed.

Dr. Fortescue was born in Cornwall, and came out to Tasmania with his parents in 1840, when scarcely two years of age. His primary education he received at the Christ's College, Tasmania, and afterwards went home to England to complete his education. In London he became a student at King's College and the London University, and at the latter took the degree of M.B. in 1861. He then returned to the colonies, and for the past twenty-five years was a familiar figure in the ranks of the profession in Sydney; indeed, by many he has been regarded as our leading medical practitioner. For many years he was an hon. surgeon of the Sydney Infirmary, and held a similar position in Prince Alfred Hospital from its foundation to the time of his death. Respected for his skill in the profession he for so many years adorned, he was no less beloved in private life for the many kindly and genial qualities he possessed. He inspired confidence in all who knew him. His genial countenance and the manly strength of his presence were the true indications of a noble mind. He was pre-eminently "manly"—courageous, true hearted, candid, affectionate, and absolutely trustworthy. Of wide reading and general culture he was without a touch of pedantry, his judgments on all questions being marked by that lucid magnanimity, which only comes from the highest combination of intellect and temper. His own saying, that absolute "sanity" was the highest human quality, was thoroughly exemplified in his own character. With perfect clearness of intellect he was never afraid to allow his heart to guide his head; while he was thus thoroughly practical, he was never cold nor narrow in his views; and his opinions on all subjects were firm, large and tolerant. It

is no exaggeration to say that the community has suffered a loss in the death of Dr. Fortescue which can hardly be repaired. Without being a prominent public man he had a wide influence even outside his own large circle of friends. He followed public affairs very closely, and he had an unswerving belief in the political future of Australia. He has left to all Australians the example of his life and character; and he has given to those who were privileged to know him an influence which will never die. The rich completeness of his character, the clearness of his intellect, and, above all, his great faith in human nature, will be a guiding star to many through all their lives. By his good work, and for his estimable life, his name in New South Wales will be lastingly remembered and cherished. Dr. Fortescue was only 47 years of age at the time of his death.

GEORGE JAMES RENWICK, M.B. ET
CH. M., EDIN.

DR. GEORGE JAMES RENWICK died at Pitt Street, Redfern, on the 21st May, 1885, at the early age of 27; a native of Sydney, his loss is deeply felt by a wide circle of friends.

Dr. G. J. Renwick had abilities of a very high order. At school he carried off all the prizes it was possible to win, and, after a distinguished course at the Sydney Grammar School, he left for the Sydney University in 1874, winning fresh honour by taking the Scholarship in Natural Science. In 1876, at the beginning of his third year, he won the Belmore Medal for proficiency in Geology and Practical Chemistry, and the following year he took the degree B.A. He then left for Scotland to study medicine, and after a distinguished career at the Edinburgh University he graduated M.B. et Ch. M. in 1881. He returned to Sydney in 1882, and from the beginning he was unusually successful in practice; he became one of the honorary physicians to the Sydney Hospital, and was appointed Medical Officer to some of the principal lodges in the metropolitan district. Until the failing health of the last six months compelled him somewhat to relax, he worked very hard in the pursuit of his profession. With great skill in diagnosis and treatment, he possessed an engaging manner, which endeared him greatly to his patients; he was known for his kindness to the poor, his urbane disposition, and his happy temper. The profession in Sydney has sustained, by the death of Dr. Renwick, a severe loss, and many of its members have lost a sincere friend.

THE MONTH.

FIJI.

THE Royal Humane Society of Australasia have presented the Clarke Medal to the Hon. Dr. Wm. McGregor, C.M.G., Administrator of the Fijian Government, who in connection with the wreck of the ship *Syria* on the Nasalai reef on May 13, 1884, exhibited peculiar bravery in his efforts to save life. This medal, provided for by donation of Sir. W. J. Clarke, of Victoria, is to be given in the case in which the most conspicuous bravery has been shown.

NEW SOUTH WALES.

AT THE last meeting of the Directors of the Prince Alfred Hospital, Sydney, the following resolution was carried on the proposition of the Hon. Secretary, Dr. F. Norton Manning:—"That the Directors of the Prince Alfred Hospital desire to record their deep feeling of regret at the death of Mr. George Fortescue, M.B., the senior surgeon to the hospital. The directors have long been aware that his operative skill, his great general and professional ability, and his devotion to duty in connection with the hospital, have enhanced its reputation, and contributed in no small degree to its success; and they are now keenly sensible that his death is a great and abiding loss to the hospital, which he so faithfully served, as well as to the public generally." It was further resolved that a copy of the above be forwarded to Mrs. Fortescue.

A letter was also read from Dr. A. Murray Oram with reference to the erection of a memorial tablet to the late Dr. Fortescue. It was as follows:—"Prince Alfred Hospital, Sydney, June 9, 1885. Sir,—The members of the honorary medical staff of the hospital being desirous of erecting a memorial tablet to the late Mr. Fortescue, I have been requested to ask whether the board of directors would have any objection to such a tablet being placed in some frequented part of the institution, and to ask the board to kindly suggest a suitable position for the memorial. I have the honour to be your obedient servant, A. MURRAY ORAM. The Honorary Secretary of the Prince Alfred Hospital." The permission to erect a tablet was granted, the site to be selected by the house committee.

AT a recent meeting of the Directors of the Prince Alfred Hospital, Sydney, a letter was read from the secretary of the medical board giving reasons for considering it necessary that the admission of typhoid cases should not exceed one-quarter of the number of patients in the medical wards of the institution. The proceedings that have arisen out of this question are to be brought under the notice of the Government, with a strong recommendation from the board as to the establishment of a fever hospital.

THE epidemic of typhoid fever in Sydney and the suburbs is on the increase, and is causing a good deal of uneasiness. The total number of cases in the various hospitals comprised in the metropolitan district is 144. At the Coast Hospital, Little Bay, there are 65 cases, of which 48 are of an acute nature. There are 28 cases in the Sydney Hospital, 34 cases in the Prince Alfred Hospital, all in the acute stage, and 17 cases in the St. Vincent's Hospital.

TWELVE of the N.S.W. Contingent who are down with sickness, were left at the Colombo Hospital, under the care of Surgeon Proudfoot. Eleven of the cases are typhoid fever, and three of the patients are in a critical condition.

A PAINFUL accident happened to Dr. Joseph Beeston at Newcastle yesterday morning. Whilst he was riding along Hunter-street, his horse shied and collided with a timber cart. Dr. Beeston had his leg broken and was severely shaken. Dr. Ashe set the limb, and the patient is now progressing favourably.

HON. Surgeon O. S. Evans has been promoted to the rank of Staff-Surgeon, and Hon. Assistant-Surgeon Dr. S. T. Knaggs to be Surgeon in the Naval Brigade; Dra. G. W. Baker and T. M. Kendall have been appointed additional Honorary Assistant-Surgeons to the Naval Brigade.

DR. H. FOORD-CLARK, of Moree, has removed to Tamworth.

DR. A. FORBES, of Murwillumbah, in the Tweed River district, has gone home; he has been succeeded in his practice by Dr. J. A. Pybus, who for the last six months assisted Dr. R. D. Jones, of Bowral.

THOMAS WILFRED HAUGHTON, M.B. et Ch. B., T.C., Dub., 1883, died at Tamworth on June 3.

DR. COLIN HENDERSON, the recently appointed medical officer of the Bathurst Hospital, having resigned, a committee meeting was held on May 26 to appoint his successor. There were only two applications in, and that of Dr. H. A. Clowes was accepted.

DR. GEO. HURST, has resigned the office of Lecturer in Clinical Medicine at the Sydney University in consequence of circumstances which necessitated his retirement from the position of Honorary Physician at the Prince Alfred Hospital. The directors of the latter institution have expressed their regret at the loss of his services, and resolved that a communication should be forwarded to him, thanking him for the manner in which he had carried out the duties of his office.

DR. H. D. JONES, of Bowral, has gone to England on a visit; Dr. B. J. Newmarch, late of Windsor, will carry on the practice during Dr. Jones' absence from the colony.

DR. H. LILIE, late of 177 Liverpool Street, Sydney, has commenced practice at Moree, in a farming and pastoral district, 391 miles N.W. of Sydney.

DRS. J. MCLEOD AND F. WADHAM have been appointed Surgeons in the N.S.W. Volunteer Force.

DR. J. B. NASH, of Lambton, has been appointed Captain of the 4th Regiment, New South Wales Volunteer Infantry.

DR. W. S. PARTRIGE, of Gunning, has removed to Stroud, the principal town at Port Stephens, in an agricultural and pastoral district, 124 miles N. of Sydney.

NEW ZEALAND.

WE learn that the Christchurch Hospital is working satisfactorily now that Dr. Symes has been appointed Surgeon, in place of Dr. Nedwill, and it is to be hoped that in future the hospital will be conducted without further scandal.

A MEDICAL Society has been established at Wellington; Dr. A. Johnston has been elected its first President.

THE Colonial Secretary having issued a new regulation, the object of which is stated to be "to prevent the Wellington Hospital being filled up with cases which should not be sent to it," the medical men of Wellington consider themselves insulted, and demand the withdrawal of the insinuation.

At the last monthly meeting of the Greymouth Hospital Committee, it was resolved that the Treasurer telegraph to the Colonial Secretary's Department, that unless Government place the Committee in funds to meet the expenditure at the end of the financial year, on or before 27th May, the Committee will tender their resignations.

TYPHOID fever is prevalent in Wellington. Fourteen cases are in the hospital.

A MEETING was held at Christchurch on April 31, to take steps to establish a branch of the St. John Ambulance Association. There were about 100 persons present, including Drs. Hacon, Brittin, Moorhouse, Guthrie, and Anderson. Dr. Hacon, who is an honorary member of the St. John Ambulance Association, referred to the fact that he had introduced ambulance work in New Zealand by instructing the Armed Constabulary in the North Island in 1881. He quoted from a leading article of the *Lyttelton Times* on Sept. 8, 1884, advocating the establishment of such a society here. He explained the working of the Association in England, and gave several simple illustrations of the good that could be done to a sufferer by anyone who was in possession of what he might term a few "medical tips." In order to show the practical work that could be done on the battle-field, several members of the City Guards, who have been instructed by Dr. Brittin, formed a stretcher with greatcoats and rifles, and Dr. Brittin explained how easily and comfortably a wounded man could be carried off the field by this method. Finally it was resolved "That a branch of the St. John Ambulance Association be formed, to be called the Canterbury, New Zealand, Branch of the Association." Over 60 of those present entered their names as members, and the meeting terminated.

A LARGE number of lunatic patients from Christchurch, Napier, and Wellington, have been removed to the new asylum at Seacliffe, near Dunedin.

Dr. D. BLAIR, of Invercargill, has removed to Waitahuna, in a mining and agricultural district, 52 miles S.W. of Dunedin.

Dr. J. F. CAROLAN has commenced practice at Helensville, on the southern shore of Kaipara harbour, 80 miles N. of Auckland.

Dr. S. H. EDGELOW, of Helensville, has removed to Whangarei, in an agricultural and coal-mining district, 80 miles N. of Auckland.

Dr. G. L. L. LAWSON, late of Candelo (N.S.W.), has commenced practice at Devonport, a favourite suburb on the shore of Auckland harbour, $2\frac{1}{2}$ miles N.E. of Auckland.

Dr. A. B. MORRIS, late of Kerseong, in Bengal, East India, has commenced practice at Tauranga, on the Bay of Plenty, 130 miles S.E. of Auckland.

QUEENSLAND.

A HOSPITAL and Surgeon's quarters are to be erected at Geraldton, the centre of the Johnstone River sugar-growing district, 80 miles N.W. of Townsville.

DRS. J. C. ELLISON, JAS. HILL, AND J. R. BENSON, of Brisbane, have been appointed Members of the Queensland Pharmacy Board, for the purposes of the Pharmacy Act of 1884.

Dr. G. SPELLINI, Medical Officer of the Palmer River District Hospital at Maytown, has resigned and left for Brisbane.

SOUTH AUSTRALIA.

THE Governor in Council has authorised the establishment of a school of anatomy in connection with the University of Adelaide, at the anatomical theatre and lecture-rooms on the land and premises of the University, situated on North-terrace, Adelaide.

Dr. HORATIO THOMAS WHITTELL has been appointed an inspector of schools of anatomy, and he has also been directed to superintend the school of anatomy established in connection with the University of Adelaide.

Dr. ARCHIBALD WATSON, Elder professor of anatomy, and Dr. Edward Charles Stirling, lecturer on physiology at the University of Adelaide, have been licensed to practice anatomy at the school of anatomy, established in connection with the University of Adelaide, for and during such time as they hold the appointments of professor of anatomy and lecturer on physiology at the said University of Adelaide.

THE position of pathologist at the Adelaide Hospital has been offered to Dr. Watson, professor of anatomy at the Adelaide University, who, it is understood, is willing to accept the position.

Dr. J. D. DUNLOP, the senior house-surgeon at the Adelaide Hospital, has forwarded his resignation to the hospital board. The board accepted the resignation from July 12, regret being expressed that ill-health had caused Dr. Dunlop's retirement.

EDWARD HAMILTON BLAIR BARKER, M.B., Melb., 1876, Public Vaccinator and Health Officer for Robe, was found dead in his bed on May 20. The deceased gentleman was formerly deputy medical superintendent at the Ararat Lunatic Asylum, Vic.

TASMANIA.

TYPHOID fever has been rather prevalent in the colony for some time past, but it is now abating.

VICTORIA.

At a meeting of the Council of the Melbourne University, held on May 11, it was unanimously resolved: "That the following be added to chapter xiii., section 7, of the regulations:—Medical students who are called out for active service in the Victorian militia, shall not on that account lose their year on account of missing lectures."

At a meeting of the Council of the Melbourne University, held on June 8, a somewhat serious charge was brought by Mr. W. A. Wood, a medical student, against Dr. Fulton, one of the examiners in the theory and practice of medicine. He accused Dr. Fulton of telling him in a loud tone and excited manner that he would be sorry for what he had done in making a complaint against him (Dr. Fulton) to the University Council. The occurrence was alleged to have taken place in ward 20 of the Melbourne Hospital, in the presence of several medical students. The letter containing the charge was ordered to be forwarded to Dr. Fulton for his reply.

MAJOR-GENERAL DOWNES, Secretary of Defence, has written to the Alfred and the Melbourne Hospitals, requesting the committees to nominate one of their surgeons to attend a Medical Board, to report upon—(1) number of patients each hospital could take in the event of war; (2) means of accommodation; (3) extra, if any, surgical appliances required; (4) how many surgeons, nurses, and dispensers could be lent from each hospital to the medical staff in the field. The

letter was referred to the medical staff of each hospital for report.

A BOARD to consider the question of the treatment of sick and wounded in the field commenced its sittings at the Defence department, Melbourne, on June 10. The chairman is Surgeon-Major Fulton, the principal medical officer of the forces, and the other members are Surgeon-Major Fetherston, Dr. Blair, and Dr. Llewellyn.

A PROPOSAL has been made in Melbourne by Dr. Rose and others to establish a temperance hospital, in which patients may be treated entirely without the use of alcohol, except in rare cases, in which it may be prescribed as a drug.

At the last meeting of the committee of the proposed Victorian Temperance Hospital, the hon. secretary reported that negotiations were in progress for obtaining suitable temporary premises in Powlett Street, East Melbourne. Mr. W. Lodge was appointed assistant secretary and collector for the institution, and it was stated that the Melbourne Total Abstinence Society had voted the sum of £500 towards the building fund, and a less sum, the amount of which was not stated, for maintenance. The committee hoped to be ready for the reception of patients within a few weeks.

DURING the past year the number of children registered in Victoria as vaccinated was 21,307, while the total number of births was 28,850, the percentage of vaccinations being 73.88.

THE CENTRAL Board of Health have called the attention of the police to the necessity of seeing to the enforcement of the vaccination laws.

At the meeting of the Central Board of Health on May 15, it was stated that hydatids are becoming very common in Victoria. The chairman stated that Iceland ranked highest as regarded the prevalence of the disease, and Victoria came next. It was decided to urge the health officers and State-school and other teachers to prevent as much as possible the children from using water after dogs have been drinking it.

IN reply to a question relating to milk from inoculated cows, asked by Dr. James, of Heidelberg, the Central Board of Health expressed the opinion that it would be perfectly safe to allow of the use of milk from cows which had been inoculated for the prevention of pleuropneumonia, a fortnight after the inoculation had taken place.

On the recommendation of the Central Board of Health, the Chief Secretary has decided to appoint Dr. Robert Wright, at present of Junee, New South Wales, to succeed Dr. Porter as health officer at Port Phillip Heads. The salary for the position is to be £400 per annum. Dr. Wright was selected out of nine candidates.

At a meeting of the council of the St. John Ambulance Association, held at Melbourne on 3rd June, Surgeon-Major R. Robertson, of Charnwood Crescent, St. Kilda, consented to act as honorary secretary in the place of Dr. R. B. Warren, who has left for Wagga Wagga. A vote of thanks was accorded to Dr. Warren for his past valuable services.

THE third of a series of lectures on "Nursing" has been delivered by Dr. Rothwell Adams at the Alfred Hospital. The subject was "Anatomy," and the lecturer succeeded, by means of models and diagrams, in thoroughly securing the attention of his audience. At the end of the series prizes will be given, after examination, for knowledge of anatomy and physiology, to the nursing staff of the hospital and outside com-

petitors. Of the ladies present, 15 gave in their names as competitors.

THE fourth of a series of lectures in connection with the training school for nurses was delivered at the Prince Alfred Hospital, on May 22, by Dr. Schlesinger. There was a large attendance, and the lecturer explained in a lucid manner the treatment of fractures of different bones of the body.

DR. WIGG, of Carlton, on 23rd May, gave a lecture at the Spencer-street railway station to the newly-formed ambulance class, numbering between forty and fifty members from all branches of the service. Instruction was given in the art of bandaging and the relief of simple accidents, in which great interest was evinced by all present, engine-driver and clerk being alike eager to learn. The lecture, which is the first of a course, was illustrated by anatomical diagrams, and each member of the class was presented with the handbook of the St. John Ambulance Association. The proceedings closed with a unanimous vote of thanks to Dr. Wigg.

Measles is very prevalent in Camperdown. There have been over 200 cases in a fortnight, two of which terminated fatally. There have also been a few cases of typhoid fever.

DR. S. A. BERNAYS, the well-known oculist of Melbourne, has been appointed Surgeon and Geologist to the Expedition despatched by the Geographical Society of Australasia for the exploration of New Guinea.

DR. G. R. W. ADAM, of East Melbourne, has resigned his appointment as Public Vaccinator for Collingwood.

DR. G. A. BRANSON, of Jerilderie, N.S.W., has removed to Tungamah, a post town 156 miles north of Melbourne.

DR. S. W. BRIERLEY, Deputy Medical Superintendent of the Beechworth Lunatic Asylum, has resigned his position.

DR. J. C. C. DURHAM, late of Sydney, and formerly of Pebleton, N.Z., has commenced practice at Shepparton, an agricultural township on the Goulburn river, 113 miles north of Melbourne.

DR. F. W. A. GODFREY, Acting Assistant Medical Officer at the Melbourne Hospital, has resigned his position, he being about to proceed to England. Dr. Bage, who had previously taken charge of the out-patients was appointed in his stead.

DR. C. E. GRAY, of East Melbourne, has removed to Horsham, to take charge of the practice of Dr. Cross during this gentleman's absence from the colony.

WILLIAM AUGUSTUS HEISE, M.B., Dublin; M.R.C.S.E., 1838, formerly of H.M. 26th Regiment, died at Sandhurst on 19th May.

DR. R. MORROW, late of Ballyjamesduff, County Cavan, Ireland, has settled at Colac, in an agricultural and pastoral district, 96 miles south-west of Melbourne.

DR. C. F. PORTER, Resident Medical Superintendent at the Quarantine Station, Point Nepean, has resigned his position.

DR. R. B. WARREN, of North Brighton, will leave Victoria shortly, with the intention of settling at Wagga Wagga, N.S.W.

DR. A. E. WOODFORD, late of Spencer's Wood, Reading, England, has commenced practice at St. Arnaud, an important township in a pastoral and mining district, 165 miles north-west of Melbourne.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

- Browne, David Graham, M.D. & Ch.M., Qu. Univ., Irel., 1871.
 Power, Richard, L.R.C.P., Edin., 1864; L.R.C.S., Irel., 1863.
 Pockley, Francis Antill, M.B. & Ch.M., Edin., 1884; M.R.C.S., Eng., 1884.
 Colpe, Johannes Christopher Ludovic, M.D., Leipzig, 1884; Staats Examen. Cert., 1872.
 Cummings, Harold Lytton, L.R.C.P., Lond., 1884; M.R.C.S., Eng., 1884.
 Cameron, Malcolm L., M.B., Trin. Coll. Univ., Canada, 1881; L.R.C.P. & R.C.S., Edin., 1881.
 Massey, Harry Massey, L.R.C.P., Lond., 1882; M.R.C.S., Eng., 1883.
 Bickle, Leonard Watkins, L.R.C.P., Lond., 1881; M.R.C.S., Eng., 1881.

NEW ZEALAND.

- Morris, Andrew Bernard, L.R.C.S. & L. Med. & Mid., K.Q.C.P., Irel., 1871.

VICTORIA.

- Woodforde, Alfred Ernest, L. & L. Mid., R.C.S. & R.C.P., Edin., 1884.
 Durham, John Charles Crozier, L. Med., 1871, & L.R.C.S., Irel., 1870; L. Mid. Coombe Lying-in Hospital, Dublin, 1871.
 Gault, David, L. & L. Mid., R.C.S. & R.C.P., Edin., 1880.
 Morrow, Robert, M.B. & Ch.B., Dubl., 1884.
 McLennan, Warwick Guy, M.R.C.S., Eng., 1881; L.R.C.P., Edin., 1881.

MEDICAL APPOINTMENTS.

- Anderson, Eugene Wilton, M.B. & Ch.B., Melb., L.R.C.P. & R.C.S., Edin., to be Government Medical Officer and Vaccinator for the district of Balranald, N.S.W.
 Blair, David, M.D., Glas., to be Public Vaccinator for the Waitahuna district, N.Z.
 Boyd, James, M.D., St. And.; L.F.P.S., Glas., to be Health Officer for Huntley shire, Vic.
 Branson, George Attenborough, L.R.C.P., Ed.; M.R.C.S.E., to be Public Vaccinator for Tungamah, Vic.
 Brock, Edward, M.R.C.S.E., to be Health Officer for shires of Broadford and Pyalong, Vic.
 Clindenning, William Talbot, M.R.C.S.E., to be Brigade Surgeon on the Staff of the South Australian Forces.
 Clune, Thomas Benedict, L.R.C.P., Edin.; L.R.C.S., Irel., to be a Surgeon of the N.S.W. Volunteer Naval Artillery.
 Davy, Thomas George, M.R.C.S.E., appointed Surgeon Superintendent of the Kumara Hospital, N.Z.
 Durham, John Charles Crozier, L.R.C.S., Irel., to be Public Vaccinator for Shepparton, Vic.
 Evans, Owen Frederick Seymour, L.R.C.P. & R.C.S., Edin., to be Assistant Surgeon of the Volunteer Naval Artillery.
 Frankish, John David, M.D., St. And., M.R.C.S.E., to be Hon. Surgeon of the Canterbury Honorary Reserve Corps of Volunteers, N.Z.
 Gillon, George Gore, M.B. & Ch.M., Glas., to be Honorary Surgeon in the Wellington Naval Artillery Volunteers.
 Grant, David, M.B. & Ch.M., Edin., to be Assistant Medical Officer at the Hospital for the Insane, Callan Park, N.S.W.
 Gray, Charles Edward, M.D. & Ch.M., Dubl., to be Acting Health Officer for Wimmera shire, Vic.
 Halket, Laurence John, L.R.C.P., Lond., to be Government Medical Officer and Vaccinator for the district of Quirindi, N.S.W.
 Hunt, Frederick Everard, M.R.C.S.E., L.R.C.P., Ed., to be Honorary Surgeon of the Richmond Rifle Volunteers, N.Z.

Jack, Robert Nelson, L.R.C.P. & R.C.S., Edin., to be Health Officer for shire of Stawell, Vic.

James, Henry, M.R.C.S.E., L.R.C.P., Edin., to be Public Vaccinator at Heidelberg, Vic., *vice* Dr. Bleeck, resigned.

Knowles, William Bisset, M.D. & Ch.M., Aberd., to be Government Medical Officer and Vaccinator for the district of Inverell, N.S.W.

Macartney, George William, L.R.C.P. & R.C.S., Edin., to be a Surgeon in the Queensland Marine Defence Force.

McCulloch, Stanhope Hasting, M.B. & Ch.M., Edin., to be a Surgeon in the N.S.W. Volunteer Force.

McFarlane, Colin Campbell, L.R.C.P. & R.C.S., Edin., to be Public Vaccinator for Collingwood, Vic.

Marks, Charles Ferdinand, M.D., M.R.C.S.E., L.K.Q.C.P., Irel., to be a Surgeon in the Queensland Defence Force; also a member of the Queensland Central Board of Health.

Ogg, Alexander Stark, M.B., L.R.C.P., Edin., to be Government Medical Officer and Public Vaccinator for the district of Gundagai, N.S.W.

Preston, Alfred Chevallier, L.R.C.P., Ed., M.R.C.S.E., to be Public Vaccinator for the Christchurch district, N.Z.

Russell, Bartholomew Taylor, L.R.C.S., Irel., L.K.Q.C.P., Irel., to be Government Medical Officer and Vaccinator for the district of Merriwa, N.S.W.

Ryan, Edward, M.B., Melb., to be Health Officer for Lowan shire, Centre Riding, Vic.

Stirling, Edward Charles, M.D., Cantab., F.R.C.S.E., to be a member of the South Australian Medical Board.

Taaffe, John Ferdinand Hugh, L.S.A., Lond., to be Public Vaccinator for Balaklava, S.A.

Thomson, John, M.B. & Ch.M., Edin., Surgeon-Major, to be Surgeon to "A" Battery of the Permanent Defence Force, and to the officers and men of the Queensland gunboats "Paluma" and "Gayundah" while in port.

Thorpe, Samuel, M.R.C.S., Eng., to be Public Vaccinator for the Buller district, N.Z.

Treadder, Edward Stanley, M.R.C.S., Eng., L.R.C.P., Lond., to be Government Medical Officer and Public Vaccinator for the district of Coonamble, N.S.W.

Vance, Noel Crawford Atterbury, M.B. & Ch.B., Melb., to be Health Officer for shire of Melton, Vic.

Vaughan, Alfred Purdue, M.B. & Ch.B., Melb., appointed Resident Medical Officer at the Sick Children's Hospital, Adelaide, S.A.

Warren, Richard Benson, F.R.C.S., Irel., L.K.Q.C.P., Irel., to be Acting Public Vaccinator for Brighton, Vic.

BACILLUS SUBTILIS IN ENTERIC FEVER.

(To the Editor of the A.M.G.)

SIR,—Please add to my notes on Enteric Fever, published in the March number of the *Gazette*, the following reference which I omitted:—

"Almaquist has cultivated microbes in normal human blood serum through several generations, and inoculated a dog through the second generation fluid—the dog was killed in fifteen days; Peyer's patches were much swollen, and contained characteristic microbes.

There were six different forms:—(1) rods; (2) thin threads to which the rods grow; (3) fine mycelium; (4) zoogloea masses of fine granules; (5) irregular granular masses—granules ovoid, little defined, of variable size; (6) protoplasmic masses more or less granular. These forms are rich in cultivating fluid, contain cells and form round and ovoid granules." [*Nordiskt Medicinskt Arkiv*, Bd. XIV., No. 10.] Yours &c.,

JOHN REID, M.B. & Ch.M., Aberd.

Port Germein, South Australia.

REPORTED MORTALITY FOR THE MONTH OF APRIL, 1885.

Cities and Districts.	†Population.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from							
				Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Child-bearing.
N. S. WALES.											
Sydney	103,379	211	70	...	1	4	1	15	14	22	...
Suburbs	120,832	294	164	...	1	14	1	18	30	22	1
NEW ZEALAND.											
Auckland	28,245	35	18	...	...	4	...	2	3	4	...
Christchurch	16,378	21	2	...	...	...	...	...	...	4	...
Dunedin	24,865	27	6	...	...	...	...	1	1	4	...
Wellington	22,885	34	12	...	...	1	...	1	1	2	1
QUEENSLAND.											
Brisbane	26,557	56	30	*	...	...	...	...	...	...	...
Suburbs	9,612	40	17	...	...	...	...	...	...	...	...
SOUTH AUSTRALIA.											
Adelaide	318,339	306	136	1	...	13	...	16	28	22	1
Adelaide	43,969	63	24	...	...	...	...	4	10	7	...
TASMANIA.											
Hobart	28,908	33	9	2	...	...	...	2	1	5	...
Launceston	18,142	21	11	...	...	2	...	6	4	1	...
Hospitals, Asylums, Gaols, &c. .	1,201	27	...	...	...	...	...	...	...	...	...
Country Districts	85,358	...	...	...	...	...	...	...	...	...	...
VICTORIA.											
Melbourne	65,791	90	220	...	...	14	2	25	40	60	4
Suburbs	238,618	475									

* The Official Monthly Report on the Vital Statistics of Brisbane and Suburbs does not show the number of deaths from the various diseases.
† The population of N. S. Wales, Victoria, Adelaide, and Queensland, is that of the census of 1881; New Zealand, South Australia, and Tasmania show the estimated population at the present date.

METEOROLOGICAL OBSERVATIONS FOR APRIL, 1885.

STATIONS.	THERMOMETER.					RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.	Mean Height of Barometer.	Depth.	Days.		
						Inches			
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E. ....	...	85.2	63.	46.2	30.090	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.	140.	70.	59.5	48.	...	.540	12	71	...
Brisbane—Lat. 27° 28' 8" S.; Long. 153° 16' 15" E.	161.	89.	71.6	52.	30.220	1.28	12	71	N.E.
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E. ....	...	...	...	...	...	...	...	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.	122.	73.	51.9	38.	...	2.938	15	74	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E. ....	...	74.	54.9	34.7	30.181	.78	7	82	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E. ....	...	74.2	56.1	31.2	30.249	.14	4	73	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	...	83.6	57.2	40.	30.148	2.50	9	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ....	...	77.3	64.6	47.9	30.251	1.40	12	74	N.E.
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	130.	68.	55.1	40.	...	2.760	11	84	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

MICRO-CHEMICAL OBSERVATIONS ON THE BLOOD IN HEALTH AND IN TYPHOID FEVER.

READ BEFORE THE VICTORIAN BRANCH OF THE
BRIT. MED. ASSOCIATION.

BY THOMAS SHEARMAN RALPH, M.R.C.S., ENG.,
PRESIDENT MICROSCOPICAL SOCIETY OF
VICTORIA.

(WITH COLOURED PLATE).

THE ordinary examination of the blood by means of the microscope reveals only its organic constituents, *i.e.*, the white and red corpuscles floating in the liquor sanguinis, with a few minute bodies regarded as lymph or chyle corpuscles; but this mode of investigation does not inform the observer of changes effected in it which can be regarded as pathological. The occurrence of red corpuscles with crenated edges, or the comparative excess of the white over the red, or non-formation of rouleaux, &c., being appearances which probably are due to physical changes in the plasma, and, therefore, can scarcely be regarded as indications of degeneration. It has appeared to the author that changes such as can be effected in the corpuscles themselves and the supporting fluid by the use of chemical agents, are likely to be serviceable to the pathologist by indicating (from analogy) what may be effected in the elements of the blood by more subtle agents generated in it, and which most likely are due to the operation of vital forces, and are not referable merely to the agency of chemical forces.

With a view to indicate such, it is needful to commence *ab initio*, that is, first to deal with blood in that condition wherein we suppose it to be normal. Here, at this first step, we are liable to meet with conditions which may considerably alter the blood, and thus add to our difficulty in

determining what is or is not normal. Nevertheless, it is my expectation that a steady observation of the blood, under apparently healthy conditions, ought to yield reliable results to work upon, and I therefore submit some observations on the blood in health and disease, which have occupied my attention during past years, to the notice of other observers and workers, with a view to their recognition and introduction into pathological research.

The red and white corpuscles need only to be mentioned in opening up this subject, and also the phenomena of coagulation, whereby the corpuscles become more or less welded together. Let us then take the blood on a glass slide. This is most conveniently and least painfully obtained from the lobe of the patient's ear, by a slight incision with a lancet, the first portion being wiped away, in order to cover the neighbouring cuticle with a kind of protective covering, so as to exclude any cuticular scales in the drop of blood to be wiped on the slide. The blood having been received near one end of the slide, should be swept to the other by means of another slide placed edgewise and drawn over it from one end to the other, so as to constitute a thin film of blood—it being desirable, in some cases, to examine a single layer of corpuscles in place of a sheet composed of several. This done, the film of blood may be allowed to dry or not, according as the operator deems fit. Placing then a thin glass cover over a portion of the film he applies a chemical agent by means of a glass rod (not a pipette) as the glass rod can be effectually cleaned at once by water and wiping, and afterwards, if needful, passed through the flame of a spirit lamp.

There are several chemical agents to which attention may be directed, each presenting some variation as to action, but bringing out changes which bear upon the structure of the blood corpuscles.

The first to be introduced is a compound called "Phloro-glucen" ($C^6. H^6. O^3$) dissolved in hydrochloric acid. A very small drop of this is to be applied to the edge of the cover glass, and its effects watched under the microscope with an amplification of 250 or 300 diameters. The red corpuscles should be somewhat separate from each other, and not dried on the glass, and it will be seen that as each corpuscle is attacked the contained matter separates into two portions, one which is solid, of a greyish hue, and the other, generally much less in bulk, of a fluid or viscid appearance, most of these presenting a roundish form, or constituting two or three smaller spots of

a reddish hue. The corpuscles thus acted on often assume an ovate form, in place of the spherical or discoid.

This change in the corpuscles is very interesting to observe, as it so definitely points out the existence of two distinct elements conjoined in the corpuscles, but apparently forced asunder by the chemical agent. A less decided but similar effect is obtained by the use of phosphoric acid united with hydrochloric. (The ordinary phosphoric acid can be evaporated on a glass slide, and the hydrochloric acid used to solve it.)

A third agent is ozonic ether, which has a decided rapid action on the blood, evidenced by an effervescence the moment it comes into contact with it.

The most favourable mode of experimenting is to use a slide with a dry, uncovered film of blood on it, and draw rapidly across it a glass rod which has been quickly dipped out of the ozonic ether. The moment the contact is made, the film of blood, to the naked eye, appears whitened all along the course taken by the glass rod. Place the slide at once on the microscope stage, under a 1-inch objective, or a power of 40 diameters, and a puzzling field of disengaging bubbles will present itself. These bubbles must be carefully watched, and it will be noted that they emerge from the welded mass of corpuscles and escape through some fissure made in a large cell which has been first formed by the distension effected by the gas on one or more corpuscles. When the effervescence has lessened or nearly ceased, a number of large cells, varying from a $\frac{1}{1000}$ th of an inch in diameter to $\frac{1}{100}$ th of an inch, will be found, composed of the material of the corpuscles, which have been attacked, and constituting a more or less united cellular mass, most of the elements of which appear to have burst.

Besides all this, it will be noticed that each of these cells contains a small vesicle or gas bubble, of a reddish or orange tinge, which itself enlarges more or less, and sometimes nearly fills the primary cell, or disappears, or remains stationary—some appearing permanent, that is, lasting for hours. The reddish orange tinge lessens as each vesicle enlarges into a gas bubble, and when seen free from the parent cell it will be found to possess a minute covering film of fibrine (?), and to exhibit a halo-like appearance round it. Multitudes of these objects can be seen, some imprisoned, unable to escape, because developed deep down in the coagulum formed by the corpuscles.

The action of the ozonic ether, which is very violent and confusing at first, can be greatly modified by using glycerine very slightly charged

with the ozonic compound, *i.e.*, 1 part to 50 of glycerine.

If a cover is employed, the bubbles of gas cannot readily escape, and the confusion is greater than when viewed uncovered. When the commotion has subsided somewhat, the vesicles can be examined under a $\frac{1}{4}$ -inch objective (300 to 350 diameters), the blood film being uncovered, and the minute objects alluded to will be found enlarging and presenting the peculiar appearance of a vesicle, minute in size, and when seen free in the surrounding fluid, exhibiting a white halo surrounding them, due to the difference in density compared with the supporting fluid. These objects also present a to and fro kind of movement, most probably due to chemical change going on within them. The general action of effervescence appears to be the result of chemical action in the corpuscles by the ozonic ether, and not a mere liberation of the oxygen of the ether, for no reaction takes place at some portions of the blood films at times, or scarcely if it has been severely heated over a spirit lamp flame. After the film has dried spontaneously from the action of the ozonic ether, it can be preserved by the application of Canada balsam under a glass cover.

The action of peroxide of hydrogen is somewhat similar, but its use is not so satisfactory, as it is combined with a little sulphuric acid, and this may give rise to the formation of crystals.

Another experiment which introduces some change in the development of the above phenomena of coloured vesicular forms consists in the employment of hydrocyanic acid (Scheele's). A film of dry blood is prepared, and a glass rod, dipped in the acid, is rapidly drawn across it, and allowed to drain or dry off. This portion of the film can be examined with a $\frac{1}{4}$ -inch objective, and is to be kept under view for 5 or 10 minutes, in order to allow of changes which follow its use. At first, the portion examined may yield nothing decided; next may be observed the presence of minute reddish or orange coloured dots imbedded in the disintegrated film of corpuscles. These increase in size, and vary in number, according to the condition of the blood examined. Sometimes they occur arranged in a circle, or circles, which appear to mark out the limits of the corpuscles which have adhered to the glass. If these minute vesicles are not seen, then they will be replaced by much larger ones, constituting distinct recognizable gas vesicles. There are other changes which will be alluded to by-and-bye.

Thus far we have evidence of changes effected in the constituents of the blood in a normal state, and similar changes can be brought out in typhoid blood. But typhoid blood, examined

without the aid of chemical agents, presents, under ordinary circumstances, the orange red vesicular forms imbedded in the plasma. They vary in size from $\frac{1}{1000}$ th of an inch in diameter to $\frac{1}{100}$ th, possess a movement when not bound down in the plasma, as when water is added; they exhibit a white, halo-like appearance surrounding them; most of them increase in size, assuming a dark border within the cell wall, and show that their increase in size is due to the evolution of gas within them, turning into mere gas bubbles, occasionally of large size. They appear also to assume an elongated form, and might be taken for bacteria, or even bacilli; but when noticed in this stage, the action of ozonic ether carefully brought to bear on them generates gas, and the observer finds out at length he is looking at a gas vesicle, bounded by a film of fibrine (?). The film may collapse from the escape of the gaseous element, and then will be seen lying crumpled up out of shape.

The action of ozonic ether appears to release orange coloured vesicular forms in a more permanent condition, and in larger numbers than in healthy blood, and the use of other agents appears to confirm these results. These objects, however, appear to be distributed in the plasma, and also in the corpuscles, the former fact not being noticeable in healthy blood, but from which they are made to emerge by the ozonic ether as described. These spherular objects (vesicular forms) seen in typhoid blood are not evenly distributed through it, but appear rather in batches on slides taken in triplicate, &c., from the same patient at one and the same time. They seem also, to make their appearance in the plasma after a slide has been condemned as being deficient in exhibiting their presence satisfactorily.

I have no hesitation in making these statements, as I have examined scores of slides prepared from over 40 or 50 cases of typhoid in different stages. When the blood of a fatal case of typhoid is examined, it will be noticed that it has become disintegrated, and that the yellowish or orange coloured vesicles are diffused through it to a much greater extent; and when the film of blood is examined along its free edges, where there is less pressure than in the central thicker portions, bacilli or bacillar forms are seen imbedded in the plasma—these objects appear of a reddish hue. Occasionally they may be noticed to be divided across by a transverse line into two portions, thus presenting still more the features of a fungoid nature. Associated with these are other forms of a similar size, but of a grey hue, and appear to break up under ozonic ether. Some, however, which cannot be distinguished from those that assume the gaseous change show

a blackening of the encasing, or peripheral portions, which under higher powers appears to be due to the minutest development of gas limited to the investing membrane.

This blackening of the edge of a bacillus I have noticed to occur in bacteria, &c., not derived from blood or animal tissue—as in bacteria derived from the cells of *vallisneria*.

The changes in the corpuscles of the blood which I have endeavoured to bring before the notice of the Society, regarded merely from a chemical point of view, are curious and interesting, but when considered under a higher aspect, that is, that all these objects are the subjects of organic force or vital energy, we find ourselves on the borders of a still more difficult inquiry. In many of the examinations made, one is almost sure to obtain evidence of growth-like forms which, on the one hand, may be referable to chemical action set up, and assuming conditions and appearances by which we are induced to class them as crystalline. Such, no doubt, is the true interpretation of the nature of some. But there are other forms which as undoubtedly claim, by appearance and character, to be vegetals of the very lowest and most obscure class, and we should be careful not to fight against their appearance and claim to this status, as was done years ago against *zeptothrix* and *micrococci* making their appearance in specimens of blood and being straightway relegated to the nature of concretions or forms of fibrine.

These peculiar evolutions of form are best developed in the blood film after the action of hydrocyanic acid, both in health and fever blood specimens. These objects are not like those which Professor Beale alludes to in his work, "How to work with the Microscope," for they are four or five times the diameter of a red corpuscle, branching out like fungi of low form, and presenting occasionally, at their terminal points, a minute reddish molecule strongly simulating a spore-form. Others, again, having originated from a blood corpuscle, and having encircled it, pass beyond it. Occasionally they present a tinge of reddish hue. Many bacillar forms have been seen, which, by some observers, would be declared to be crystals; but such of these as present a minute red molecule at one end are curiously unlike crystals in their physiognomy. Again, it is needful, in the interests of this enquiry, to advance a further statement—that it appears whenever the blood is made the subject of severe chemical action, as in the exhibition of chloroform, the plasma of the blood exhibits these escaped vesicular forms, and perhaps more abundantly than in typhoid and other febrile conditions, as scarlatina and rubeola.

A word about culture. If a film of blood is operated on by hydrocyanic acid, or any other suitable agent, the slide can be inserted into a large test tube, previously sterilized by igniting alcohol in it, and carefully closing it until fitted with the slide to be examined. The ordinary temperature of a room for some hours will suffice for trial, but there should be a little vapour of distilled water admitted to the tube.

THE following observations, which have been made since the reading of the paper will greatly assist in repeating the experiments with the chemicals I have indicated.

The phloroglucin (dissolved in hydrochloric acid) when applied to typhoid blood in a dry film on a slide (by carrying a streak of the compound across the film, and allowed to dry), and examined with a power of 250 diameters, shows that the red corpuscles are attacked in much the same manner as by hydrocyanic acid, as indicated; that is, without evolution of gas, as with ozonic ether. But in thus experimenting with the phloroglucin compound, I find that the orange coloured objects make their appearance in the coagulated plasma of the blood, which is situated between the clustered red corpuscles, and which plasma appear as clear, empty spaces; and it is noteworthy that these objects have not been brought out under the direct action of the fluid chemical applied, but that the plasma has been permeated to a great distance, by imbibition, from where the phloroglucin has been directly applied, and thus the orange coloured objects have been liberated, not from the surrounding red corpuscles (which at this part can be seen to be unacted upon), but released from the plasma itself. Now, the action of the phloroglucin on normal blood treated in the same way does not appear to react in this manner, or to such a degree; for, wherever the chemical has flowed over the red corpuscles, there they are seen to be dissolved to some extent, and the orange coloured objects are revealed, and the process of imbibition (if it has taken place) seems to yield no such marked results as in the case of the typhoid film.

As the phloroglucin is not easily attainable in the colony, the following will yield very similar results, and is in the reach of any ready microscopist.

Take the phosphoric acid of the Br. pharmacopœia and evaporate some of it on the end of a glass slide to the consistence of a syrup, then add hydrochloric acid to the extent of one-tenth of the original or fluid phosphoric acid, and mix thoroughly. This combination appears to act as well as the phloroglucin, care being taken that the hydrochloric acid is not in excess.

DESCRIPTION OF PLATE.

- Fig. 1. Red corpuscle.
2. Two red corpuscles after the application of Phloroglucin.
3. Cells formed from several red corpuscles, after action of ozonic ether, exhibiting fissures, (a), with a yellow or pale orange coloured object in a cell.
4. Other red corpuscles, after ozonic ether, two lower with yellow objects. (a.) A yellow vesicle formed by the gaseous distension of a yellow object. (b.) Another contained in the dilated vesicle, c.
5. A yellow corpuscle separate from cell. No. 1 and this are relative sizes.
6. A yellow vesicle exhibiting increase, and showing a white peripheral area.
7. Same becoming larger, with a darkened inner cell wall.
8. Red corpuscles after action of hydrocyanic acid; yellow objects seen without previous formation of cells, as in 3 and 4.
9. A red corpuscle from a typhoid case, presenting a more yellow tinge than ordinary.
- 10 and 11. Yellow objects found in the blood film in typhoid, without any extraneous chemical action, relative size to 9.
12. A film of typhoid blood acted on by ozonic ether, same as 3 and 4.
13. A film of typhoid blood heated over a spirit lamp, exhibiting yellow points brought out by the heat.
14. Gas vesicles after action of ozonic ether on objects resembling bacteria.
15. Other forms seen in (fatal) typhoid blood.
16. Action of hydrocyanic acid on normal blood film, after the lapse of some minutes. Five red corpuscles on the left to show relative size of the four vegetation (?) forms on the right. The three right hand figs. are red corpuscles which have flattened out and exhibit vegetation forms.

Kew, MELBOURNE, May 20, 1885.

SOME NOTES ON THE RECENT SMALL-POX CASES FROM SYDNEY, AND ON THE VACCINATED CONDITION OF THE QUARANTINED.

By JOHN SERVICE, L.R.C.S. and L.R.C.P., Ed.,
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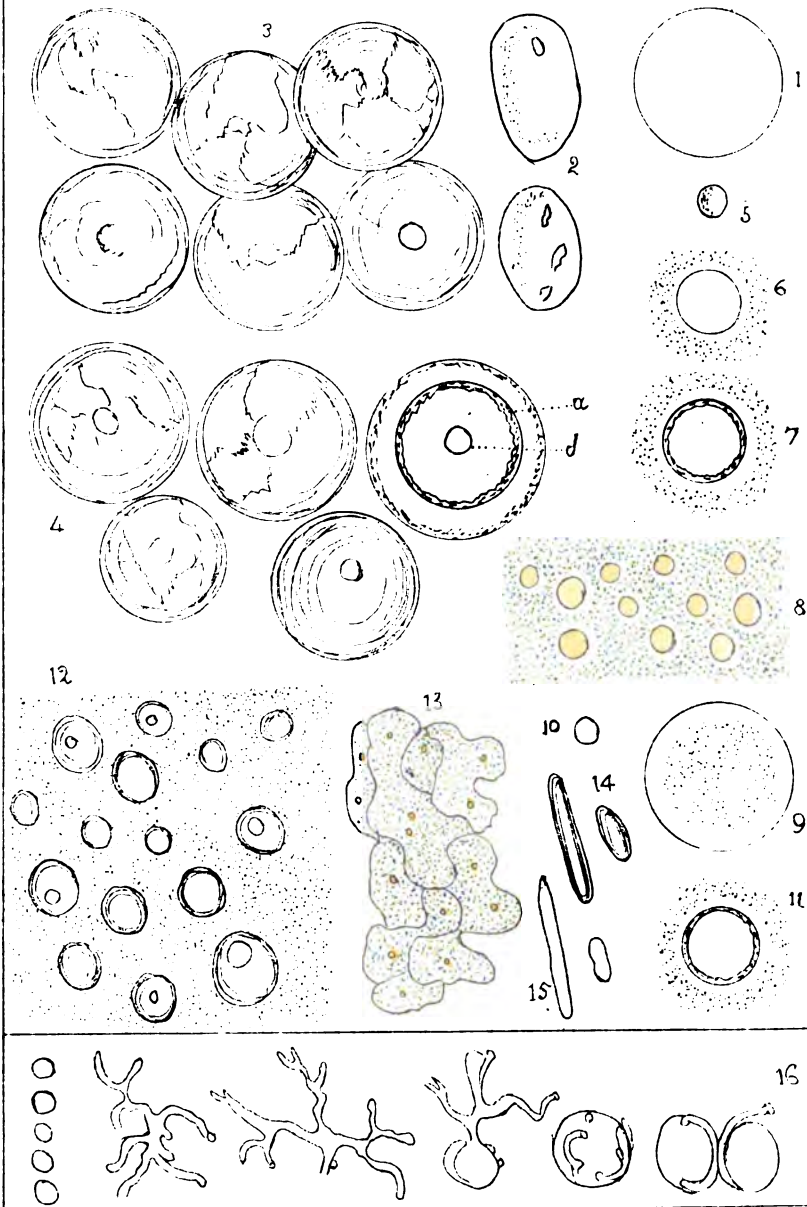
WITHOUT entering into any clinical details, which, from the ordinary nature of the cases, and the absence of anything unusual to the disease, is unnecessary, I wish to place on record a few tabulated statements in connection with the recent outbreak of small-pox in Sydney.

SYMPTOMS.

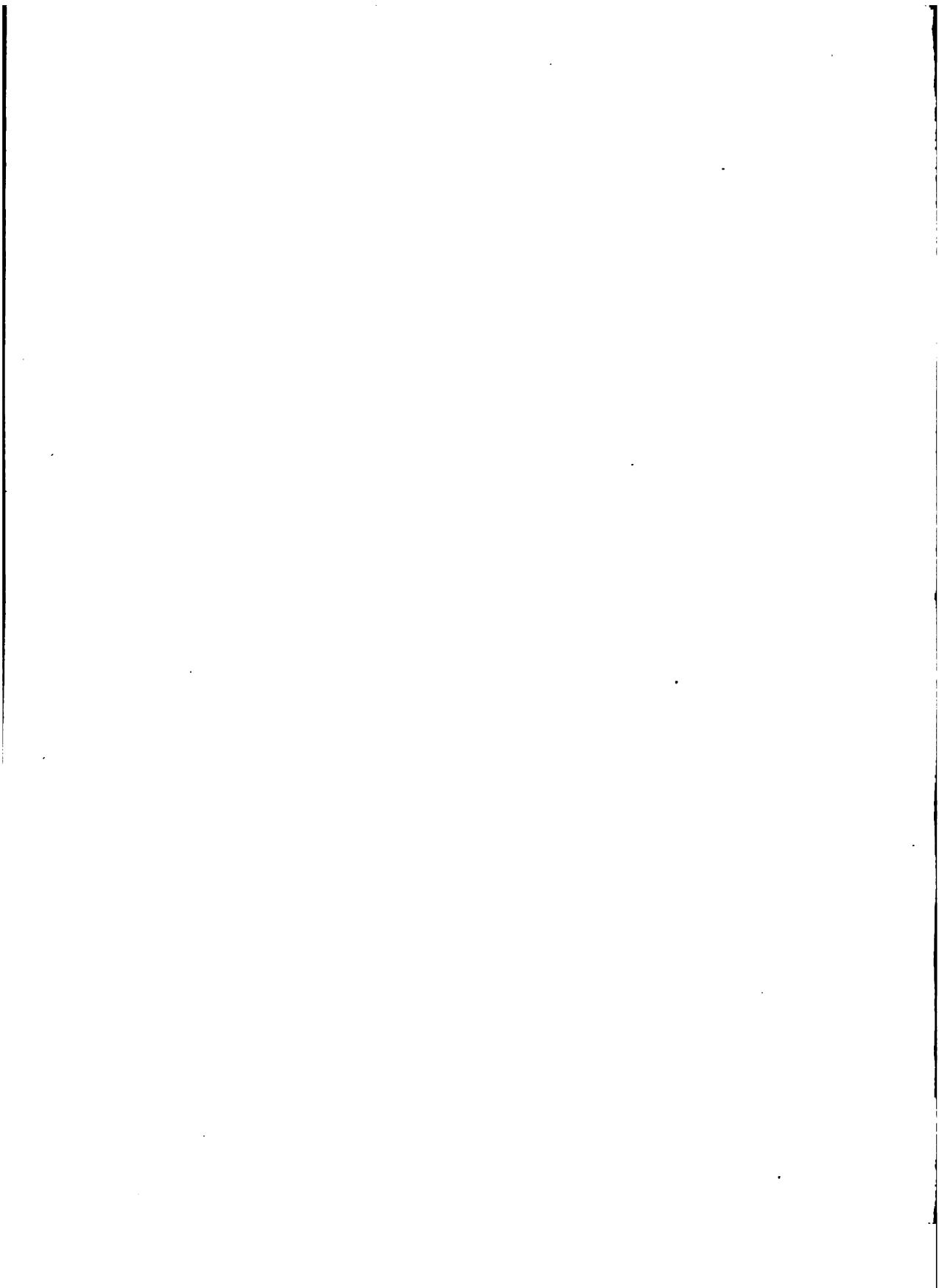
On no occasion was a hyper-pyretic temperature registered, 104.2 F. being the maximum even in the fatal cases. Lumbar pain was not a marked feature in any case.

COMPLICATIONS.

Except in two of the fatal cases, there were none of any consequence. Diarrhoea occurred in



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a few instances, but was easily checked. The fatal cases were these:—

1. John C——, æt. 34, unvaccinated, died on the 17th day, one mass of suppuration. For five days he had obstinate diarrhœa.

2. Elizabeth S——, æt. 47, unvaccinated, was admitted Dec. 24th, moribund, and died next day, on the 18th day of the disease. She had bronchitis and congestion of the lungs.

SEQUELÆ.

Troublesome boils were frequent, but yielded to iron and nutritious diet.

A weakly strumous lad of 8, after passing through a severe attack of variola discreta, died of broncho-pneumonia. He, also, was unvaccinated.

The following table shows the protective marks found on all who arrived at the Quarantine Station from Nov. 27th, 1884, till March 14th, 1885, and also the ultimate marks with which they left:

				On arrival.	Ultimately.
Having	12	vaccination	cicatrices	1	2
"	10	"	"	—	1
"	8	"	"	1	3
"	7	"	"	—	4
"	6	"	"	2	18
"	5	"	"	2	15
"	4	"	"	25	38
"	3	"	"	44	43
"	2	"	"	64	44
"	1	"	"	46	26
"	1	inoculation	cicatrix	4	4
"		no vaccination	mark	36	26
				225	225

Of the foregoing, there were—

Vaccinated before	Revaccinated before
arrival .....162	arrival 15
Vaccinated on	Revaccinated on
arrival 44	arrival .....105
Never vaccinated	19
225	120

THE FOUR CASES OF ALLEGED INOCULATION.

1. John McG——, 42, was 12 years old when inoculated. Had some spots on arms and legs, and remembers that he was done from the medical man's niece, who had small-pox at the time. Mark cicatricial. Vaccination failed.

2. Mary McM——, 42, remembers being ill after the operation in childhood. She shows one or two pits on left leg. The inoculation mark on the right arm is cicatricial, round, nearly as large as a shilling, and has a trace of foveation at one of its edges. Vaccination unsuccessful.

3. Thomas George H——, 50, was nine or ten years old when inoculated, and remembers distinctly being ill afterwards. He had some spots, and his hands were tied to prevent him scratching them. Mark on arm much the same as in last case; vaccination failed.

4. Helen C——, 50, has a cicatricial mark on arm resembling the others; vaccination failed.

Of the 26 who ultimately showed no protective vaccination or inoculation mark—

13 had recently had small-pox in a severe form, and of these 13 three died, one on the 13th, one on the 17th, and one on the 34th day of the disease.

3 children, æt. respectively 6, 5, and 1 years, had just had the disease in a moderate form.

8 children, æt. respectively 1 year, 2 months, and 14 days, had had very mild attacks, the youngest of the three being scarcely ill at all, and showing an eruption which might certainly have been strophulus. Vaccination however, twice repeated, was unsuccessful.

1 had had small-pox in infancy.

2, after a first failure of the operation, refused to have vaccination repeated.

4 appeared to be insusceptible to vaccinia after three, four and five careful trials, but of course arm to arm vaccination was not often practicable.

26

With these few last exceptions, I had the satisfaction of seeing every one depart in a more or less protected condition, and there was not a single bad result from vaccination in any case. Tubes of both "humanized" and calf lymph were used.

Looking to *area and quality* in the vaccination marks, and taking two inches square as satisfactory, I computed that of the 225 arms examined, 81 were up to the standard and 43 more were raised to it; 48 were protected by one attack of small-pox (= 172), leaving 53 who were advised to have vaccination repeated at some future date. Cicatricial, non-foveated appearances were too common, and this, with the large number of excellent vesicles produced by re-vaccination, points unmistakeably to the urgent need there is for some well-devised scheme of compulsory vaccination.

The following table shows the vaccinated condition of the patients treated from December 12, 1884, till March 14, 1885, the character of the disease, and its duration and severity :—

HAVING FOUR VACCINATION MARKS OR VESICLES.—FOUR CASES.

Name.	Age.	Vaccinated.	Character of Cicatrices or of Vesicles.	Re-vaccinated.	Character of Cicatrices or of Vesicles.	Illness began.	Character of Eruption and of Disease.	Duration of Disease.	Amount of Pitting.
Minnie D...	11	Dec. 3 ..	Good vesicles ..	....	.....	Dec. 7	Discrete severe ..	38 days	One or two on hands.
Ernest L...	2	Dec. 3 ..	Medium vesicles ..	....	.....	Dec. 7	Discrete severe ..	38 days	Face, arms and hands.
Hen'tta S...	15	Dec. 24 ..	Good vesicles ..	....	.....	Dec. 31	Semi-confident ..	55 days	Face, arms and hands.
Beatrice S...	11	Dec. 24 ..	Good vesicles ..	....	.....	Dec. 31	Semi-confident ..	48 days	Face, arms and hands.

HAVING THREE MARKS OR VESICLES.—ELEVEN CASES.

Emma D...	16	Dec. 3 ..	Good vesicles ..	....	.....	Dec. 7	Semi-confident ..	56 days	Face.
Chas. A. J...	32	In infancy	Indistinct cic.	....	.....	Nov. 23	Confident ..	70 days	Face and hands.
Peter C....	35	In infancy	Indistinct cic.	....	.....	Dec. 2	Discrete ..	35 days	One or two on face.
Leslie L....	4	Dec. 3 ..	Medium vesicles ..	....	.....	Dec. 8	Discrete ..	24 days	
Gert'de L...	5 m.	Dec. 3 ..	Medium vesicles ..	....	.....	Dec. 7	Very slight... ..	8 days	
Phoebe L...	29	In infancy	Small cicatrice ..	....	.....	Dec. 6	Very slight... ..	8 days	
Alfred L...	15	In infancy	Good cicatrice ..	....	.....	Dec. 21	Discrete mild ..	30 days	
Annie M. F.	7	January 14	Small and poor ves.	....	.....	Jan. 18	Discrete severe ..	44 days	
Geo. E. H...	4	In infancy	Medium cicatrice...	Jan. 17	3 medium ves.	Jan. 21	Discrete very mild	18 days	
Mabel H...	6	In infancy	Medium cicatrice...	Jan. 17	Failed ..	Jan. 17	Discrete very mild	17 days	
Joseph J...	24	In infancy	Good cicatrice ..	Nov. 30	3 medium ves.	Dec. 5	Discrete very mild	12 days	

HAVING TWO MARKS OR VESICLES.—EIGHT CASES.

Hannah C...	30	In infancy	Medium cic.	....	.....	Nov. 24	Discrete severe ..	43 days	.....
Richard B...	25	In infancy	Small cic.	....	.....	Nov. 25	Discrete ..	35 days	.....
Jane M....	33	In infancy	Good cic.	....	.....	Dec. 11	Discrete ..	39 days	.....
Fred. K....	4	Dec. 3 ..	Small and poor ves.	....	.....	Dec. 11	Discrete ..	39 days	.....
Fred. S....	18	Dec. 24 ..	Good ves.	....	.....	Dec. 29	Discrete ..	18 days	.....
Annie J. F.	27	At 7 years	Medium cic.	....	.....	Dec. 16	Very mild ..	28 days	.....
William C...	23	In infancy	Faint cic.	....	.....	Jan. 21	Discrete ..	39 days	.....
Olive B....	30	In infancy	Medium cic.	....	.....	Oct. 25	Confident ..	98 days	Face ..

HAVING ONE MARK OR VESICLE.—SIX CASES.

Austin T. ..	2	Nov. 29 ..	Medium ves.	....	.....	Dec. 8	Discrete mild ..	32 days	Hands, one or two on face..
Charles T...	30	In infancy	Good cic.	....	.....	Nov. 22	Discrete severe ..	54 days	A few on face..
James B...	18	In infancy	Good cic.	....	.....	Nov. 25	Discrete ..	41 days	A few on face..
Mary E. T...	30	In infancy	Good cic.	....	.....	Dec. 9	Very mild ..	8 days	.....
Joseph S...	67	In infancy	Medium cic.	Dec. 24	.....	Dec. 25	Discrete ..	60 days	.....
Thomas J...	25	In infancy	Faint cic.	....	.....	Feb. 20	Discrete ..	28 days	.....

HAVING NO VACCINE MARK AT ALL.—NINETEEN CASES.

Emma L. ..	12	Nov. 24	Confident ..	69 days	Face and arms	Died
Sophia B. ..	8	....	.....	....	.....	Nov. 25	Confident on face	81 days	Face and hands
Rachel M...	6	....	.....	....	.....	Nov. 24	Confident ..	52 days	Face and arms
John C....	34	....	.....	....	.....	Nov. 29	Confident ..	17 days	.....
Henry K. ..	8	Nov. 23	Confident ..	58 days	Face, arms and hands	Died
Helen R....	9	....	.....	....	.....	Nov. 24	Discrete severe ..	58 days	Face and arms
Herman D...	9	....	.....	....	.....	Nov. 22	Discrete severe ..	58 days	Face and hands
Elizabeth S.	47	....	.....	....	.....	Dec. 13	Confident ..	18 days	.....
Violet F. ..	6	Jan. 6	Discrete severe ..	42 days	Face and hands	Died
Joseph F. ..	24	....	.....	....	.....	Jan. 7	Discrete severe ..	48 days	Face and hands
Joseph F. ..	8	....	.....	....	.....	Jan. 4	Discrete severe ..	54 days	Face and hands
Laura F....	13	....	.....	....	.....	Jan. 4	Discrete severe ..	44 days	Face and hands
Joseph C...	10m	Nov. 3	Semi-confident ..	25 days	Face and legs..	
Beatrice-McQ	2m	....	.....	....	.....	Dec. 16	Discrete mild ..	30 days	.....
Alice M. H.	1	....	.....	....	.....	Dec. 25	Discrete very mild	25 days	.....
Thos. McM.	6	....	.....	....	.....	Dec. 28	Discrete ..	44 days	Wrist and feet
Patrick McM	5	Jan. 5	Discrete ..	49 days	Hands ..	
Edwd. McM.	1	....	.....	....	.....	Dec. 22	Discrete ..	49 days	Face ..
Edward L. P.	14d	(?)	Discrete ..	(?)	

In the following cases, with the exception of the last of them, the vaccine areola had not had time to develop before the invasion of variola, and they may, therefore, be classed as unmodified cases. Nevertheless, the local vaccination phenomena followed a normal course, and in one case at least, that of Gertrude L., æt. 5 months, the small-pox attack was mild in character. In three other infants, Beatrice McQ., æt. 2 months, Alice

Mary H., æt. 1 year, and Edward L. P., æt. 14 days, all of whom were unvaccinated, the disease was also of an exceedingly mild type; and in this connection it is worthy of remark that, if there be a typical period of life at all in which there is perfect health and all the disease resisting power implied thereby, it is during the first few months of life when the child is receiving only its natural nourishment.

No.	Name.	Age.	Vaccinated.	Illness began.	Vaccine Vesicles developed.	Character and Duration of Disease.
1	Minnie D...	11	Dec. 3, which was 10th day of incubation	Dec. 7, or 4 days after vaccination	4 good.. ..	{ Discrete severe, 38 days.
2	Ernest L. ..	2	Dec. 3 " 10th "	Dec. 7, or 4 " "	4 medium ..	{ Discrete severe, 38 days.
3	Henrietta S.	15	Dec. 24 " 7th "	Dec. 31, or 7 " "	4 good.. ..	{ Semi-confident, 55 days.
4	Beatrice S..	11	Dec. 24 " 7th "	Dec. 31, or 7 " "	4 good.. ..	{ Semi-confident, 48 days.
5	Emma D. ...	16	Dec. 3 " 10th "	Dec. 7, or 4 " "	5 good.. ..	{ Semi-confident, 55 days.
6	Annie M. F.	7	Jan. 14 " 10th "	Dec. 18, or 4 " "	{ 3 small and poor ..	{ Discrete severe, 44 days.
7	Gertrude L.	5 m.	Dec. 3 " 10th "	Dec. 7, or 4 " "	3 medium ..	{ Very mild, 8 days.
8	Fred. K. ...	4	Dec. 3 " 6th "	Dec. 11, or 8 " "	{ 3 small and poor ..	{ Discrete, 39 days.
9	Austin T...	2	Nov. 29 " 5th "	Dec. 8, or 9 " "	1 medium ..	{ Discrete mild, 32 days.

CASES OF DIGITAL EXPLORATIONS OF THE BLADDER.

READ BEFORE THE MEDICAL SECTION OF THE ROYAL SOCIETY OF NEW SOUTH WALES.

By SAMUEL T. KNAGGS, M.D., F.R.C.S.I.

WE are indebted to Dr. Rowling, of Parramatta, for bringing prominently under the notice of the profession in this colony Sir Henry Thompson's method for "Digital exploration of the bladder, through incision of the urethra in the perineum."

Dr. Rowling gave us a very favourable exposition of Sir Henry Thompson's views, by detailing four interesting cases in which he had adopted this feasible method of diagnosis and surgical treatment with most satisfactory results.

At the time when Dr. Rowling read his paper—about a year ago—I had under my treatment two cases, which presented many difficulties as to accurate diagnosis by the usual methods of examination, and with your kind permission I shall briefly detail these cases.

Case 1.—S.B., an anæmic, delicate-looking lad, aged 22 years, native of this colony, was admitted into St. Vincent's Hospital, under care of Dr. Schuette, for chronic cystitis, with dysuria and occasional discharges of pus from the bladder, accompanied by other symptoms, which obscurely indicated a cystic calculus. Several examinations by means of the sound gave negative results, and

the course of treatment adopted was with the view of improving the general health of the patient.

He came under my care in May, 1884. His principal symptoms then were frequent and painful micturition at variable intervals, pangs of excessive pains shooting down the thighs and to the end of the penis, which attacks would culminate in a copious deposit of pus, and occasionally blood in the urine, which was occasionallyropy with mucus. The urine was slightly albuminous, but not more than would be expected to originate from the pus and blood that were voided.

Unhappily, as his general health improved, so did his painful symptoms increase, and such became the extent of his sufferings, that he begged that something should be done to relieve him, so with the consent and assistance of the staff of the Hospital, I proceeded to explore the bladder, according to Sir Henry Thompson's method, on 1st July. I had no difficulty in reaching and entering the bladder, but it was found to be in such an abnormal condition that one of my colleagues, who explored it after the operation, for a moment doubted that the bladder had been entered. Instead of the smooth, velvety lining, the finger encountered a contracted cavity, irregularly doubled by hard fibrous trabeculae. Towards the right side a thickened mass was felt in the wall of the bladder, that led to a suspicion of a malignant deposit.

The patient experienced considerable relief from his sufferings, induced, no doubt, by the rest to the bladder which resulted from drainage through the opening in the perineum. He rallied for a few days, when symptoms of uræmia set in, and he died on the 9th day from the date of the operation.

The bladder, or that which represented that viscus, is before you. When recent it showed evidences of very severe inflammatory action, the mucus coat being in some cases quite eroded, and the muscular coat laid bare.

Of the prostate gland only the capsule is left, and what remains of the bladder is but a pocket of sufficient size to contain a large walnut. This was lined with a highly vascular bleeding surface, presenting appearance something like fungus hæmatodes. It was the junction between the fibrous capsule of the prostate gland and the abnormal bladder that, in the exploration operation, divided the cavity which represented the bladder, into two irregular spaces.

The right ureter was degenerated into an impervious cord. The kidney of that side had undergone cystic degeneration. The left ureter was widely dilated, and appeared to have taken on the vicarious functions of a bladder. The kidney which emptied into it, presented the appearances such as is described as a surgical kidney. My friend, Dr. MacCormick, has kindly made careful sections of it, and has discovered the usual micrococci of the surgical kidney in the tubules.

Case 2.—The second case which I now bring under your notice is that of a well-built gentleman, of plethoric habit and considerable literary attainments.

He had for years been subject to albuminuria, the result of over-stimulation by means of alcoholic beverages. His age was 59, and when he first came under my care in May, 1884, he suffered from all the subjective symptoms of a cystic calculus, aggravated by the presence of an enlarged prostate, and a stricture in front of the membranous portion of the urethra. Under influence of chloroform it was possible, by dexterous manipulation, to insert a No. 6 sound into the bladder. No calculus could be felt, but there was a sensation of grittiness, which indicated a calcareous deposit around the neck of the bladder.

I had him moved into a private ward in St. Vincent's Hospital, and there had the benefit of the advice of my colleagues, who after careful observation concurred in the opinion that the albuminuria contra-indicated any operative procedure, either for the detection or removal of the calculus, should such be present. Every possible

palliative treatment was tried, but without avail, for his relief.

I may say that his sufferings were greatly increased, and our efforts at palliation were greatly hindered, by his having been for years a victim to self-induced morphia narcosis, to the extent of 12 to 20 grains of morphia per diem, injected by means of a hypodermic syringe. This not only caused him to be acutely sensitive to pain, but rendered inoperative as sedatives, extraordinary doses of opium preparations.

He left the hospital very much disheartened at the end of May, 1884—remaining still under my observation, and in July his sufferings increased to such a terrible extent, that he piteously entreated that something must be done. Night and day, at intervals varying from two hours to twenty minutes—but more often the latter—most painful micturition took place. His misery and agony were pitiful to behold, and it appeared a reproach to our noble art that such misery should be tolerated without some attempt to relieve it.

Having met Drs. Rowling and Jackson in consultation, we concurred in the opinion that Sir Henry Thompson's exploratory operation was not only now justifiable, but absolutely imperative, great hopes being entertained that relief would follow from the consequent rest to, and drainage of the bladder, which the operation would cause.

The patient was moved to a cottage in a healthy suburb of Sydney, special nurses obtained, and arrangements completed so that he should be amidst surroundings where the best possible hygienic conditions could be obtained, and on the 10th August, having the active co-operation of Drs. Jackson, Rowling and Kendall, I proceeded with the operation. Being a large made man, with excessive fatty deposit in the tissues, the depth of the perineum did not make the operation an easy one. I used Symes' grooved staff for guiding the knife through the stricture, which having been of long standing, was of an almost gristley nature. Thus was I enabled to pass a No. 10 staff into the bladder, upon which I cut into the membranous portion of the urethra. The staff was then removed, and I tried to gradually insinuate my finger into his bladder, when, owing to the depth of the perineum, I found to my chagrin that the point of my finger would only reach the mouth of the bladder. Fortunately, Dr. Rowling's finger was about half-an-inch longer than mine, so he utilised it, and detected a large sabulous calculus with his finger point. I at once proceeded to convert my median incision into that for the lateral operation for lithotomy, and by means of the forceps extracted large masses of agglomerated urates and phosphates.

The whole interior of the bladder was literally

lined with crystals of urates and phosphates, entangled in shreds of the degenerated and loosened lining membrane of the bladder. This was removed, and the viscus carefully irrigated. A tube was carefully placed in the opening, and the usual after treatment adopted.

For a few days the patient seemed to rally from the operation, but the result did not satisfy our expectations, for he never had any relief from his sufferings. The rest we had hoped for from drainage of the bladder did not appear to be induced. He gradually became uræmic, and he died on the 17th day after the operation.

I am indebted to Dr. MacCormick for his assistance in making a careful post mortem examination. The kidneys were found to be extensively diseased. The right one weighed 10½ ozs., had multiple abscesses on the surface, containing thick and greenish pus; the calyces were dilated, some of them containing grumous matter with gritty particles, which condition extended down the ureter. The right kidney was somewhat smaller, but presented similar pathological changes. I exhibit the bladder, the walls of which are hypertrophied, and there are still adherent to the mucous membrane masses of phosphatic deposit. I estimate the quantity of deposit to have been about three and a half ounces in weight.

In detailing these cases, I have no other object in view than of recording two cases wherein the operation for exploration of the bladder has been performed with very poor results. The necessity for the performance of the operation was not of my own election, but was absolutely forced upon me, and I took care to candidly place before my patients the risks that would be incurred.

Case 3.—I now produce an irregularly shaped calculus, covered with crystals of oxalate of lime, and weighing 45 grains, the existence of which was suspected from symptoms, but only discovered by means of digital examination through the dilated female urethra.

I saw the patient, a female aged 45 years, with Dr. Schuette in May, 1884, at which time she was suffering from oxaluria, aggravated by symptoms indicating a calculus, but which several examinations by means of a sound failed to detect.

As sedative measures gave considerable relief, I lost sight of her until last December, when all her symptoms returned in an aggravated form. Again the sound failed to detect a calculus, and I proceeded, amongst other measures, to irrigate the bladder, during which operation I thought I could detect a calculus grating against the catheter.

With the kind assistance of Drs. MacLaurin and Kendall, the patient being well under the influence of chloroform, I dilated her urethra, and had no difficulty in feeling this calculus with my finger, and readily removed it with a small forceps.

LABOUR COMPLICATED BY HÆMORRHAGE, OBLIQUITY OF THE UTERUS, AND HYDRAMNIOS.

By W. SIMPSON FLETT, M.B. AND C.M.,
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WITH a view to the better elucidation of the respective points involved, and to the more intelligible presentation of the case in hand, we propose (1) to give its history and management, (2) to discuss its complications, and (8) to consider its risks and after treatment.

I.—THE HISTORY AND MANAGEMENT.

About midnight on 6th February, 1885, I was suddenly called by an almost frantic and terrified mother-in-law to see her son's wife in Fitzroy, who had taken such an alarming flooding that she was not expected to survive. Unable to resist her importunity, I hastened to the unfortunate mother's bedside, there to find her the subject of a very extensive hæmorrhage, which had not only completely saturated her night clothing and all that had been laid underneath for the protection of the bedding, but even soaked the bedding itself through and through till the blood lay in great quantity on the floor, both below and in front of the bed.

The nature and situation of the hæmorrhage had first to be ascertained, that is, in obstetrical language, whether unavoidable or accidental, and whether *infra* or *extra* uterine.

If *unavoidable*, that of course meant *Placenta Prævia*, and would necessitate the adoption of measures commensurate with its well-known gravity. If *accidental*, then the cause had to be made out, and the appropriate means of arrest or relief applied, in order to which one must first arrive at some correct notion as to the seat of the mischief.

A vaginal examination was accordingly made without delay, which at once revealed the true state of affairs. The *absence* of anything spongy to be felt by the examining finger either over or in the immediate neighbourhood of the os uteri, which was dilated to about the size of a florin, in conjunction with no previous history of bleeding throughout the period of utero-gestation, negatived the diagnosis of *placenta prævia*, while the *presence* of some smoother tissue, readily enough recognizable as the foetal membranes, led to the conclusion that the hæmorrhage in question was accidental, and the fact of its issuing from the os was sufficiently decisive respecting its site.

Having thus settled that the bleeding was accidental in character, the next thing was to learn the *direct cause* which had excited the condition,

and obtain information as to the existence of any circumstance of the nature of accident. On instituting inquiries as to whether she had been lifting anything heavy or had had a fall, I was promptly answered in the affirmative in reference to both, it transpiring that having been engaged in a removal the previous day, she had over exerted herself, and fallen in addition, having to be lifted to bed from the floor.

The nature, cause, and situation now apparent, the practical question resolved itself into how best to *command the bleeding point*? As the simplest and readiest means, I at once, in the first instance, resorted to postural treatment, enforcing the supine position with complete rest, and warning against movement. Knowing that no hæmostatic remedy, as far as the uterus is concerned, can be compared with the uterine contractions themselves, these I endeavoured to favour. As it happened, however, even they did not suffice to modify the flow, much less arrest it. This also must have a cause, and had to be sought for. It was found in the obliquity of the uterus. The contractions were acting at a disadvantage. Instead of the advancing head being pushed down into the pelvic cavity and compressing the bleeding part, it was being propelled in an angular direction against the sacrum, and consequently giving occasion to the perpetuation of the hæmorrhagic condition.

An abdominal bandage, roughly extemporized from an old sheet and speedily applied, rectified the malposition of the uterus, which was anterior in this case; but no sooner had this been effected (by no means an easy matter—the abdomen being very large and pendulous), than the bleeding was stayed. The next and far from unimportant part of the treatment was to get rid, as soon as possible, of all articles of personal or bed clothing that were wet and soaking with blood, since they were acting as so many poultices, encouraging and favouring the hæmorrhage.

Seeing that the patency of the os and the progress of the labour did not meanwhile warrant further interference, but more especially since the bleeding was arrested (the patient thus made comparatively comfortable), I left, with orders to be called should the symptoms return or the pains become severe.

In a very few hours I was again sent for, with the announcement that the flooding had recurred, and that the pains had rather diminished than increased. Again soon in attendance, I perceived that this recurrence of the hæmorrhage was obviously due to over distension of the uterus from excess of liquor amnii, which had materially interfered with the uterine contractions, and thus afforded opportunity for a repetition of the bleed-

ing. I found, on examination, that the labour had made considerable progress in the interval, the os being pretty well opened up. The indication now clearly was immediate rupture of the membranes, artificially, which I accordingly did, when the liquor amnii, as anticipated, rushed out in great quantity. The consequence was that, the relieved uterus being now in a position for proper and effective action, the hæmorrhage ceased, and the second stage proceeded favourably. The advisability of leaving the case to the natural efforts, or of rendering mechanical aid, next presented itself, and had to be weighed. The blood the patient had already lost, the conviction that the child was dead from a certain odour which I have never found fail me, strengthened by the entire absence of foetal movement, led me to decide for proffering assistance. Finding the Roederer obliquity well marked from the position of the posterior fontanelle with the anterior difficult of access, there was no doubt that the aid rendered should take the form of instrumental interference by forceps. Simpson's forceps was accordingly applied forthwith, and the second stage was successfully terminated; but as I had surmised, the child was dead, and had been so for days from the appearance of the integument, while the cord was flattened, bloodless, and partially decomposed.

The third stage was fortunately managed without the supervention of any bleeding to speak of. Judicious compression and manipulation of the uterus through the abdomen, brought about the necessary contraction, and the placenta was expelled, exhibiting the usual features in hydramniotic cases, with a remarkably large bag of membranes. An appropriate binder being suitably applied with attention to the scrupulous removal of all articles saturated with blood that would tend to encourage post-partum hæmorrhage, and strict injunctions to maintain perfect quiet, the ultimate issue of the labour was as satisfactory as the most sanguine could have expected, considering the exceptional circumstances.

II.—THE COMPLICATIONS

Inasmuch as they exhibit a mutual interdependence and correlation, the hydramnios predisposing to the obliquity, and the obliquity in turn predisposing indirectly to the hæmorrhage, though directly excited by the accidental circumstances attending the removal, it may be well to comment on each *seriatim*.

1. *The Hydramnios*.—This essentially consists in an over-secretion of liquor amnii or a dropsey of the amnion. The precise pathological cause is as yet undetermined; but it is evidently due to some inflammatory condition of the amnion inducing excessive secretion; though, from its association, I have, as a matter of experience,

discerned at least three distinct causal indications traceable. For example, I have found it associated with—(1) anencephalous monstrosity; (2) with single conception, and fully developed child; and (3) with twins badly developed and both equally so.

The absence of any detectable influence on the part of the mother leads me, respecting the first, to have no hesitation in attributing the hydramnios to the morbid state of the *fœtus*; the child well developed, with mother otherwise healthy, justifies the reference in the second to a diseased condition of the *placenta*, observed on its expulsion; and as for the third, a well marked hydræmic constitutional condition of the *parent*, with a tendency to manifest itself in other regions, was presumably accountable for its existence in that case. Professor Simpson found it associated with the same kind of monstrosity and also with hydrocephalus, pointing to a *fourth* causal indication, viz., that a constitutional condition on the part of the *fœtus* may predispose to it, and may perhaps be the means of exciting it. Be it an abnormal local or constitutional condition of the *fœtus*, a diseased local or constitutional state in the mother or any other determining agency, some kind of stimulus applied to the amnion excites a morbid increase in the secretion, leading to over distension of the amniotic sac with fluid, which adds seriously to the risks of the child, and (though in lesser degree) to those of the mother, as an analysis of McClintock's 33 cases proves.

The diagnosis does not present much difficulty. It may have to be distinguished from ascites and plural conceptions. No treatment during pregnancy is known to have any remedial effect, but as a complication of labour the treatment is that adopted here, viz., artificial rupture of the membranes.

2. *The Obliquity*.—This may occur anteriorly or laterally. The most common malposition, however, is the anteverted variety, and associated with pendulous abdomen and a lax condition of the parietes. The treatment in all cases is rectification of the displacement, according to its character, by position, and some retentive apparatus to keep it in its place, such as a bandage or abdominal belt; and the detrimental effects, as we have seen, may be retardation of labour and perpetuation of bleeding, which require to be obviated.

3. *The Hæmorrhage*.—Obstetricians have been in the habit of classifying hæmorrhage as accidental or unavoidable according as it occurs in the case of a normally or abnormally situated *placenta*. In the present instance the placental

site was normal, and, therefore, it comes under the designation of accidental.

An *accidental hæmorrhage* means some separation of a properly placed *placenta* occurring before delivery, and necessarily resulting in effusion of blood from the lacerated utero-placental vessels. This may assume two very different phases, that is, it may escape externally or collect internally, may be apparent or concealed, the former obtaining in this case.

The ETIOLOGY is varied, consisting of—

(1st.) *Accidental* causes, such as—slipping down stairs, falls, blows, heavy lifts, &c.

(2nd.) *Local* causes, such as—too strong uterine contractions, exceptional determination of blood, degenerations and diseases of the *placenta*, &c., and

(3rd.) *Constitutional* causes, such as—albuminuric, anæmic, chlorotic and hæmorrhagic states. The exciting cause, in our case, belonged to the first category.

Regarding the PATHOLOGICAL source of the hæmorrhage, various theories have been propounded from time to time, which it would be unprofitable to discuss; but it is now universally admitted to be the *denuded uterine surface*, whether accidental or unavoidable. Even the detached portion of *placenta* theory, which was based upon the accurate observation that bleeding ceased in cases where there had been expulsion of the *placenta* before the birth of the child, has had to give way before the results of scientific investigation. The observer of a fact is not always the best interpreter of its proper significance, and the researches of Barnes, Duncan, and Mackenzie have demonstrated that it was a mistaken application of the phenomenon in question to localize the bleeding point in the *placenta* rather than in the uterus, and to conceive the hæmostatic agency to be in the placental separation instead of the uterine contractions. Granted, while the detachment is in *process* and the vessels but *partially* divided, that the *placenta* may *contribute* to the hæmorrhage, and that *entire* separation and *complete* division would influence the arrest to the extent in which the flow was dependent on imperfectly divided blood channels, nevertheless, Mackenzie's experiments and the fact that it occurs when these conditions are absent and no *placenta* there at all, indicate clearly enough that the true explanation of the hæmorrhage in these cases, whether as to the mode of production or arrest, is quite otherwise than the hypothesis referred to sets forth.

The TREATMENT has been already touched on in the management, and whether postural, manipulative, medicinal, or operative, must depend on the particular circumstances.

III.—THE PUERPERAL RISKS AND AFTER TREATMENT.

With the formidable array of critical possible emergencies staring one in the face, the prognosis, it must be confessed, was indeed grave, but I confine myself to those dangers only which were legitimately to be dreaded as expected and likely sequelæ of such a labour, viz., post-partum hæmorrhage, peritonitis, mammary disorders, puerperal mania, puerperal septicæmia and phlegmasia dolens.

1. *Post-partum Hæmorrhage* was the most immediate risk, and having regard to the concatenation of ominous circumstances alarmingly calculated to induce its occurrence, was one which the practitioner might with reason fear would be extremely difficult of prevention. The exhausted condition of the patient, the amount of over-distension the uterus had previously undergone, the instrumental interference, the multiparous subject, and the thermal climatic influences, all combined to favour its supervention and lead to inertia of the uterus, with its numerous uninviting possibilities. There is nothing I have ever found comparable to small doses of liquor strychniæ, frequently repeated at suitable intervals in the treatment of inertia, whether viewed prophylactically or remedially, even in cases where ergot might be contra-indicated. I have not the least doubt in this instance, where so many of the reputed causes of its production were coexistent and co-operative, that it largely contributed, together with the manipulative handling of the uterus and careful management of the third stage, to ward off this serious imminent risk, for if ever there was a case in which, hypothetically speaking, it should have happened, this surely afforded a typical example.

2. *Peritonitis*.—This was more than a probable danger, for it actually threatened or rather set in the following day. The tumefaction of the abdomen had become so marked as to frighten the attendants, and I was sent for; in fact, there was even a fear that it might become general. Extending tympanitis and severe abdominal pain were anything but reassuring. No time was to be lost. Energetic measures were called for. Hot fomentations and stupes were at once ordered and applied over the abdomen; a full dose of quinine, (with smaller doses to follow) was administered for the temperature, and a hypodermic injection of morphia given to allay pain. Fortunately, the untoward symptoms yielded to the treatment, rapidly subsided, and, to my great relief and that of the patient's friends, ultimately disappeared.

3. *Mammary Disorders*.—With a distinct history of special liability to these in former pregnancies without anything exceptional, and

the assurance that one breast had been incised no fewer than fifteen times for abscess, the outlook was certainly far from bright. Out of the many possible mammary contingencies the remarks that follow will be restricted to the lactation complication and suppurative risks.

(a). Not only had the usual so called "*milk fever*" to be anticipated and provided against, but steps had in this case to be taken for the *arrest* of *lactation* altogether. By the exhibition of properly selected galactophyga this was happily so accomplished that no bad symptoms were allowed to manifest themselves.

(b). The *prevention of inflammation and supuration* had next to be seen to, especially in view of such a predisposition to them previously, for if, when a living child was suckling and the mammae were being constantly relieved, these diseases were so prone to appear, how much more were they likely to occur in the case of a still-born infant. Their supervention, under the circumstances, seemed a foregone conclusion to friends and attendants. Nevertheless, in spite of all these unfavourable features and positive disadvantages, even when compared with former lactations which had turned out badly, it was a satisfaction to find that neither mastitis nor mammary abscess showed itself, and that the dreaded evils and difficulties were effectually overcome.

4. *Puerperal Insanity* was also to be feared, particularly since added to the exhaustion and surroundings there existed the great depression dependent upon having given birth to a dead child, which is so frequently associated with the state in question. As a matter of fact there were, for a time, manifestations of incipient puerperal mania tinged with melancholia, but they were fortunately of a transient nature and disappeared under appropriate treatment.

5. *Puerperal Septicæmia*.—Besides the ordinary circumstances incidental to parturition, which render the mother liable to this serious contingency during the puerperium, there was the death of the child in utero, and its partial decomposition on delivery. The danger therein involved, however, led to the exercise of special precautions, and recourse was had to washing out repeatedly with antiseptic lotions, so that sepsis was effectively prevented or counteracted where it had commenced. Accordingly, no signs of septic absorption appeared throughout, notwithstanding the presence of so many considerations, avowedly conducive to septicæmic and pyæmic phenomena. Leaving to one side extraneous *viæ mediæ* of the communication of septic poison to parturient females by practitioners (from post mortem examinations, that fruitful source of puerperal fever),

or by nurses and the like, from which such patients ought to be scrupulously protected, the essential point in dealing with the locally generated putrefactive products is to get the injured surface converted as speedily as possible from an absorbing to a casting off surface, and promote the maintenance of this till recovery, removing the soil suitable for the growth and propagation of the mischief, and preventing its deposit in the affected tissues. Investigation into cases of so-called blood-poisoning will confirm this, I am persuaded, more and more as regards lying-in women.

6. *Phlegmasia Dolens*.—This threatened in the right lower extremity, there being phlebitis and thrombosis in the internal saphena, but the condition was circumscribed, and the swelling limited, and was kept from further extension by rest, fomentations, and opiates.

Of the *after treatment*, besides what has been already referred to, nothing further need be said except that by proper dietetic regulation, the prompt meeting of symptoms as they arose, and careful attention to constitutional and local remedies, according to the indicated requirements, the patient made a wonderful recovery, when the varied and serious phases of the complicated case are taken into account.

MILKY HYDROCELE.

READ BEFORE THE MEDICAL SECTION OF THE
ROYAL SOCIETY OF NEW SOUTH WALES.

By THEO. M. KENDALL, B.A., SYDNEY,
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THE subject suggesting this paper was the case of a young man, an in-patient of St. Vincent's Hospital, under the care of Dr. Milford, to whom my thanks are due for the opportunities afforded of watching the case.

The patient was a thin, sallow-complexioned young man, aged twenty-six years, who made the following statement:—

"Eight years ago I received a blow on the left testicle, which soon afterwards began to swell. The swelling appeared at the bottom of the testicle, and gradually enlarged, till the whole testicle became involved. Beyond the inconvenient size, the swelling gave me little or no trouble. Six years ago I consulted a surgeon, who punctured the swelling and drew off a large quantity of milky fluid. I have had no further treatment since that time."

The patient further stated that he was a member of a healthy family, was unmarried, and had never indulged in sexual intercourse.

On the 24th June, 1884, this man was admitted into St. Vincent's Hospital. At this time the swelling was very large, of a pyriform shape, doughy to the touch, and perfectly opaque.

While the man was in the hospital, the swelling was tapped three times, a week's interval being allowed between each operation. At the two first operations the fluid evacuated was of a milky-white appearance, with a specific gravity of 1019. When allowed to stand for a time, a thick substance like cream collected at the top of the fluid. On shaking the fluid with a small quantity of ether, the milky look entirely disappeared, and the fluid became of a golden colour, like ordinary hydrocele fluid. Examined microscopically, it was found to consist of globules of an oily nature, with what appeared to be an albuminous coating floating in a colourless fluid. There was not a trace of spermatozoa.

At the third operation the fluid drawn off possessed all the characters of ordinary hydrocele fluid.

When the hydrocele was laid open for the performance of the radical operation, a large quantity of clear hydrocele fluid was evacuated. The tunica vaginalis was found to be much thickened and distended; and adherent to its inner surface were tags of organised lymph.

The wound was closed in the ordinary manner, and the patient made a good recovery.

I have ventured to bring this case to the notice of the section, because of its comparative rarity, for I have been unable to find records of more than three cases.

Of the several cases reported, not one is completely like the one before us. In Mr. Bryant's case, the milky appearance was due to the presence of seminal fluid, which had escaped from a ruptured seminal duct. Of the cases reported, those which most resemble the one before us are to be found recorded by M. Vidal, in the *Pathological Society's Transactions*; but in these, although the fluid was milky, had the same specific gravity, the same microscopical appearances, and gave the same reaction with ether, still there is not any mention of the return of the fluid to the state of ordinary hydrocele fluid.

Vidal gave the following as his theory:—

"The milky fluid contained in a hydrocele is merely ordinary hydrocele fluid, plus some of the fatty matters of the blood, probably derived from the capillaries of the tunica vaginalis."

In support of this theory, M. Vidal produced specimens of ordinary hydrocele fluid, which, on being shaken with a small quantity of animal oil, became milky in appearance.

Vidal's theory may be the true one, for we

have it on the authority of Professor Michael Foster himself, that "under certain pathological conditions, the percentage of fat contained in the serum becomes considerably increased." It is, therefore, perfectly possible that the milky appearance of the fluid was due to an increased amount of fat in the serum of the blood; but although in this way we may account for the curious appearance, how shall we account for the return of the fluid, in the case I have brought before you, at the third operation, to the state of ordinary hydrocele fluid?

Possibly this return may be due to the regularity of hospital life and diet; but even then, for so long standing a disease, a week was very short time for the effecting of so great a change.

In all effusions of serous membranes, which are of long standing, there is usually some attempt to get rid of the fluid, either by absorption or else by adhesive inflammation.

Sir James Paget, in his lectures on Surgical Pathology, states:—"The fibrinous exudations which are thrown out by serous membranes, in the attempt to set up adhesive inflammation, are sometimes attacked by fatty degeneration, and become liquefied."

Professor Virchow mentions a case of an old hydrocele in which cholesterine scales were found in the sac; and he attributes the presence of the cholesterine to fatty degeneration and shedding of the inner surface of the sac, when the cholesterine crystallised out.

Mr. Curling reports a case of old-standing hydrocele, which during life was mistaken for a tumour, but after death was found to be a hydrocele, the sac of which was filled with oleaginous matter.

All these facts tend, I think, to prove that the milky appearance of the fluid in an old-standing hydrocele is due to something more than an excessive supply of fat in the blood. That there had been an attempt at setting up adhesive inflammation, in the case I have brought before you, is clearly shown by the presence of the tags of organised lymph, and, therefore, I would put forward the following as the explanation of this curious case:—

A long-standing inflammation of the tunica vaginalis was productive of an attempt to set up adhesive inflammation by fibrinous exudation. These fibrinous exudations—the aplastic lymph of Sir James Paget, became attacked by fatty degeneration, and becoming liquefied, were mingled with the serum in the sac, which then became of a milky appearance. At the third operation the supply of degenerated tissue had become exhausted, and hence the return of the fluid to its ordinary state.

NOTES ON TWO MORE SUCCESSFUL CASES OF VAGINAL EXTIRPATION OF THE UTERUS FOR CANCER.

READ BEFORE THE N.S.W. BRANCH OF B.M.A.

By JOS. FOREMAN, L.R.C.P., ED., M.R.C.S.E.,
OBSTETRIC PHYSICIAN, PRINCE ALFRED
HOSPITAL, SYDNEY.

I HAVE very much pleasure in bringing under your notice two more cases of Extirpation; in the first place because though more difficult than the first the results are equally gratifying, and secondly because it is very opportune that we are able to add something practical from these colonies to the discussion that has recently taken place at a meeting of the Obstetrical Society of London on the justifiability of this operation. Extirpation for cancer has still a few friends, though, it seems to me, not very enthusiastic ones, judging from the report of the meeting in the *B. M. Journal* of February 7th and March 13th. I am not going into the pros and cons of the operation, that I have done on a previous occasion. The justification of these two cases is that they would have been dead, the first one some two or three months after admission; under any other kind of treatment, the second in a few days, as the disease had advanced so high in the body of the uterus that scraping could not have been of the slightest use. Instead of that they are both going about strong and well, enjoying life as well as at any previous period of their existence. The object of treatment should be, I think, not only to prolong life, but also to make it agreeable, and it is no argument against it that there is a return in most cases. In these two instances what chance has one of promising immunity, when the disease had forced itself on their notice, in one case seven months ago, and the other twelve? The disease had existed months previously, but even from these I am perfectly confident that if patients will be operated on when the disease is too far advanced for amputation of the cervix, but has not infiltrated in any degree the surrounding structures, that there is comparatively little to fear of a recurrence.

The first case is that of A. T., 45 years of age, married, and the mother of thirteen children, the youngest four years old. She has never had a miscarriage. Menstruation commenced at fifteen years of age, but for a number of years she did not see anything—to use her expression, she was no sooner out of one pregnancy than she was into another. Her present illness she dates from 7 months ago, when she had severe hæmorrhage, for which she had medical advice. It became less at the end of a week, but she has never been free from it since,

and it has lately increased so much that the patient is extremely weak and anæmic. The appetite is very bad, and she often has attacks of vomiting. She is a small woman, with well-marked cachexia. On examination, a large fungating mass is felt on the cervix, into which the finger passes easily for three-quarters of an inch. The body of the uterus is small and movable, but the right parametrium has a suspicious thickening which I hope may be only inflammatory. She was operated on on January 19th, and removed to a private ward. The steps were to open into Douglas, and then free the cervix, ligaturing as I proceeded, so as to save as much blood as possible. When this was completed, I tried to introduce the strong sound, for everting the uterus, that I had used on the first case but failed. I then passed my hand behind the body, and with the aid of a vulsellum drew it out. The ovaries were also removed, but the ligature on the left broad ligament slipped, and a great deal of blood was lost before it could be secured. A petticoat plug of iodoform gauze was left in instead of a drainage tube as previously. This was removed in 48 hours covered with lymph. The progress of the case was good. There was no bleeding, and very little discharge. She was moved into the general ward on the eighth day. The temperature was highest on the tenth day, when it suddenly went up to 102°, and the pulse to 180, but the temperature returned to normal and the pulse to 100 three days after. She kept very low for some weeks, and was discharged three months after the operation, still weak and anæmic. I saw this patient a few days since, five months and ten days after the operation. I have never seen a greater improvement in any one. She has absolutely nothing to complain of, her colour is what any young girl might be proud of; there is no discharge, no pain, eats and sleeps well. Per vaginam the cicatrix is about an inch long, about half the thickness of a goose quill, but to me there is a suspicious hardness about it which may or may not be anything of consequence. However, at present, she is to all intents and purposes in perfect health.

The second case is that of F. F., 30 years of age, married nine years ago, but been a widow three years. She has had two children—both dead—the last child she had five years since. She is a strong, stout-built woman, but very pallid. Twelve months ago she noticed a discharge and feeling of uneasiness, and nine months ago had a sudden and very profuse hæmorrhage, which has continued more or less ever since. The menstruation was always regular until the hæmorrhage set in; was small in quantity and quite painless. She now walks with difficulty,

and it always brings on fresh bleeding. She often faints, and cannot exert herself in any way. Examination gives evidence of a large mass, the size of a hen's egg, filling the vagina, and continuous with the cervix. The slightest touch causes bleeding, which is very difficult to stop. The uterus seemed fixed to a great extent, but it was very difficult to make out, owing to the large growth. She was kept in bed for a week, and everything done to check the bleeding, but unsuccessfully. As the temperature went up to 103° and the pulse to 126, I determined to lose no time, but operate in the general ward—no private ward being vacant. I operated on April 22. The large mass caused great difficulty, and for fully ten minutes I was doubtful if I should be able to get behind to cut into the peritoneum. I tried to ligature the cervix high up, so as to be able to cut the greater part of it away, but it was so rotten that it would only cut into the tissue, and she could not afford to lose any blood. By dint of patience, and a little force, I managed to make a beginning, and then all went smoothly, with the exception that I could not remove the ovaries, they being too adherent. An iodoform plug was used. Not more than an ounce and a half of blood was lost. The after progress was uninterrupted. She sat up on the tenth day, and was discharged two months after. I have also seen this patient within the last few days; though pale her colour is returning very quickly, and she feels strong and well, so much so that she is looking out for a situation as a housekeeper. There is a little discharge still, but very little, and as yet there is no sign of a new growth. There certainly will be a return here, but the operation was done to stop immediate death by hæmorrhage, and I think we are justified in saying that it has succeeded. These make the number of extirpations three, and all successful.

THE AUSTRALASIAN JOURNAL OF PHARMACY.

WE have received the first number of the first volume of the *Australasian Journal of Pharmacy*, a monthly paper, published in Melbourne under the auspices of the Pharmaceutical Society of Australasia. The periodical in question contains a number of interesting articles contributed by writers well-known in the world of pharmacy. Among these are: "Some Economic Tan Materials from Non-indigenous Plants capable of culture in Victoria," by J. Bosisto, M.L.A.; "Pharmacy and Pharmaceutical Education in Australia," by C. R. Blackett; and "Modern Botany in its relation to Pharmacy," by D. McAlpine, F.C.S. This new journal makes its appearance at a timely season, and will provide a long felt want. It commences with a guaranteed monthly circulation of 1,000 copies, and is issued gratis to the members of the Pharmaceutical Society of Australasia throughout the colonies. To non-members it will be supplied at 10s. 6d. per annum.

ASSOCIATION INTELLIGENCE.

NEW SOUTH WALES BRANCH.

THE 51st Meeting of the Branch was held in the Royal Society's Rooms, Elizabeth-street, on Friday, July 3, at 8.15 p.m. Present—Dr. O'Reilly in the chair, Drs. Foreman, Hoff, Parker, Kendall, C. Dixon, Hankins, Cuppaidge, Tarrant, McDonagh, Crago, Worrall, Twynam, Lentaigne.

Visitors—Drs. Macmillan and Chisholm.

The Minutes of the previous meeting were read and confirmed.

The PRESIDENT reported the death of Dr. A. A. West.

Dr. FOREMAN proposed, "That a letter of condolence be sent to Mrs. West."

Seconded by Dr. Tarrant, and carried.

Dr. FOREMAN read a paper on "Two cases of Vaginal Extirpation of Uterus for Cancer," which will be found on page 250.

Dr. TARRANT said, we are very much indebted to Dr. Foreman for having read this paper. Since Dr. Foreman's successes he (Dr. Tarrant) had been watching for a similar case, but had not yet been fortunate in getting one; he certainly would try this operation. He would conclude by moving a vote of thanks to Dr. Foreman.

Dr. C. DIXON said Dr. Foreman ought to be proud of his three successive operations having turned out so well, although the length of time since the first case had not been sufficient to enable one to decide whether it would recur or not. This operation was not performed by the London surgeons on account of the great risks. He (Dr. C. Dixon) supposed that Dr. Foreman would shortly have an unsuccessful case. If, however, it should happen that no recurrence in these cases took place, then it would be a triumph indeed.

Dr. WORRALL said he knew something of this case as the woman was under his treatment for a short time before going into the hospital. He (Dr. Worrall) must certainly congratulate Dr. Foreman on the success of the operation. He had met the woman in King-street a few days ago, to all intents in perfect health. The operation had without doubt saved her from immediate death.

Dr. FOREMAN, in acknowledging the vote of thanks said he was quite prepared for the worst, and he contended that, if by operating he could give the patient a few more months to live and enjoy life, he was quite justified in operating. Our object is to prolong life. He (Dr. Foreman) wished to show that at the Prince Alfred Hospital they could do as well as anywhere.

Dr. KENDALL read a paper on "Sanitary Supervision of Dairies," which will appear in some future issue.

Dr. TARRANT said that he had visited some of the dairies about Sydney. In one the cows were turned out into the yard where there was a notice posted asking people to shoot rubbish into the yard. He should like to see all milk come from the country, and he thought that this would soon be the case, as cold rooms for the storage of milk were about to be erected in the city, in connection with the South Coast Farmers' Association. It was impossible to do altogether without town dairies, and for the regulation of these he showed the draft of a bill which had been prepared for presentation to the last Parliament, but from several causes it was not brought forward. It would, however, be intro-

duced this session. If the Government would not do so, he would. He agreed with the suggestion of Dr. Kendall that a parliamentary committee should be appointed from the Association to take action in matters concerning public health. All knew the source of danger which milkmen were to the public at large, and he thought that the heavy mortality among children was due in a great measure to the contamination of the milk.

Dr. LENTAIGNE mentioned several cases which had come under his notice. One was where typhoid fever had been introduced into families through the milk having been watered from a well into which the liquid from a dunghill drained. In this place, also, they kept pigs.

Dr. CRAIG DIXON said that in one family no less than five persons were attacked by typhoid fever, and it was shown conclusively that they contracted the disease from cows which consumed water containing decomposed animal matter. In the suburb in which this family lived there were thirty other cases of typhoid, and each of these had been supplied with milk from the same dairy. Those of the profession who had seen these places must have come to the conclusion that they were serious sources of infection. He (Dr. Dixon) felt so insecure that he ordered all the milk which came into his house to be boiled before use.

Dr. TWYNAM said he would like to ask Dr. Kendall whether he thought the milk became infected by the cows drinking contaminated water. This was a question he was often asked. He (Dr. Twynam) thought that this Association should take steps in a matter of this kind, and if a medical practitioner reported to the Secretary that, in his opinion, a certain dairy was a source of infection, steps should at once be taken to bring the matter under the notice of the Government, and have the place closed at once.

Dr. KENDALL, in reply, said he was glad of the discussion which had taken place. In answer to Dr. Twynam's question, he (Dr. Kendall) did not know of any direct case of infection from this cause, but believed that cases of the kind had been directly traced to a contaminated water-supply.

Dr. C. DIXON exhibited a pathological specimen.

PUBLICATIONS RECEIVED.

The Asclepiad.—A book of original research and observation in the Science, Art, and Literature of Medicine, Preventive and Curative. By Benj. Ward Richardson, M.D., F.R.S.

Report of Proceedings of the Illinois State Board of Health, Quarterly Meeting, Chicago, April, 1885.

On some Common Injuries to Limbs: Their Treatment and After-treatment, including Bone Setting. By Edward Cotterell, M.R.C.S.E., L.R.C.P., Lond. Illustrated. London: H. K. Lewis, 1885.

The Velocity of Accommodation. By James W. Barrett, M.B., Melb., Demonstrator of Physiology in King's College, London. (From the Journal of Physiology, Vol. VI, 1, 2.

The Pathology and Treatment of Stricture of the Urethra and Urinary Fistula. By Sir Henry Thompson, F.R.C.S., M.B., Lond. 4th ed. London: J. and A. Churchill, 1885.

Diagnosis and Surgical Treatment of Abdominal Tumours. By Sir Spencer Wells, Bart. London: J. and A. Churchill, 1885.

Lunacy in many Lands.—Being an introduction to the Reports on the Lunatic Asylums of various countries, visited in 1882-5, by G. A. Tucker, and presented by him to the Government of New South Wales,

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, JULY 15, 1885.

EDITORIALS.

A PUBLIC HEALTH BILL FOR NEW SOUTH WALES.

A PUBLIC meeting was held at the Town Hall, Sydney, on June 24, to press on the New South Wales Government the urgent necessity which exists for the introduction of a Public Health Bill during the coming session of Parliament. A number of gentlemen delivered addresses to the meeting, the primate of Australia, Bishop Barry, moving one of the resolutions. Ample evidence was forthcoming as to the urgency of the proposed action, and all seemed agreed that a measure which would place matters relating to health in the hands of some body competent to carry out the necessary reforms, and take away the power to remain inert from the various local authorities is the principle on which the Bill must be framed. We are continually reminded by the words and deeds of the aldermen elected by the ratepayers how little fit, as a body, they are to possess the almost sole power of dealing with many abuses which endanger the health and physical well-being of us all. Recently, it would appear, from speeches made, that many of them hardly consider the contamination of the water-supply by the deposition of nightsoil in the water-shed a more than trivial matter, one alderman considering he had a just cause of complaint against Dr. Mackellar, the principal medical officer in New South Wales, for exposing it, and by doing so the laches of the municipal authorities. The meeting decided that a deputation should wait on Sir Alexander Stuart to press the matter on his attention, which it did, obtaining from him a promise that a Public Health Act should be one of the measures of the Government during the ensuing session, he stating at the same time that a bill was already drafted. Dr. MacLaurin, as one of the deputation, forcibly showed, by

well quoted statistics, how many cases of preventible disease, in many instances resulting in death, were consequent on the present state of things, and expressed a hope that a proper power, invested in competent authorities, would do much to alter this. Other gentlemen mentioned other matters of equal importance, and their representations were received with proper attention by the Honorable the Colonial Secretary, who thanked them for their praiseworthy efforts in so laudable a public cause.

A HEALTH OFFICER FOR THURSDAY ISLAND, TORRES STRAITS.

A DEPUTATION from the Central Board of Health in Brisbane, waited upon the Hon. S. Griffiths, the Premier, on July 3, urging the advantage of the fitting up of a hulk for the treatment of cases of small-pox in that colony; to this he gave a favourable reply. They also urged upon him the necessity of appointing a medical officer to reside at Thursday Island, for the purpose of examining vessels passing there, as to the presence on board them of contagious diseases. The deputation, it appears, suggested a salary, the amount of which is, however, not published; this sum apparently struck horror into the economical soul of luckless Queensland's Premier, for he, in the "penny wise" manner so characteristic of himself and his policy, thought it much too high, expressing his opinion that £200 per annum, with the right of private practice, would be sufficient. We think that he is wrong in his estimate, and that for that sum the colony is only likely to get some luckless professional ne'er-do-weel, who should be the last to be appointed to such a position—one where an error in judgment might give rise to unutterable evils, not only to the colony which is blessed with the possession of Mr. Griffiths, but to the rest of Australasia. It is probable that if we are cursed by the introduction of cholera—its route of arrival will be by Torres Straits—and that the stationing of a thoroughly good man as Health Officer at Thursday Island would be our strongest safeguard against it. We think this appointment a matter concerning the whole of Australia, and it is regrettable that the united action with regard to Quarantine, recommended by the late Sanitary Conference, is not promptly acted upon.

THE SPREAD OF HYDATID DISEASE.

THE Melbourne Central Board of Health have issued a useful circular for the information of the public, in relation to this matter, pointing out the dangers to be avoided and the best methods of preventing this terrible evil. It shows that next to Iceland, where one sixth of the deaths occur from hydatid disease, Victoria is more subject to it than any other country. It recommends the urgent necessity of proper care being taken by the authorities for the efficient carrying out of the registration of dogs, a matter which, though perhaps not carried out as it might be in Victoria, is, by the police authorities in New South Wales, culpably and almost absolutely neglected. It is regrettable that the power given under the New South Wales Dog Registration Act to prosecute the police officer who neglects his duty in this respect is not oftener put into force, and it might very justifiably commence with the Inspector-General, as the police officer in charge of the Metropolitan district where unregistered and ownerless dogs are almost innumerable.

By a recent minute of Sir Alexander Stuart, Colonial Secretary, it has become a rule of the New South Wales Government that, before any aid is granted by it for the erection or addition to any hospital, the plans of the proposed buildings must be submitted for the approval of the Medical Adviser to the Government, and to the Inspector of Public Charities, in order that it may be seen that they do not transgress the ordinary rules of hygiene. We are informed that this action has arisen from a minute of Dr. Mackellar, the principal medical officer, on the Newcastle Hospital, where he, on inspection, had to condemn numerous grievous faults of construction, situation and maintenance. From personal knowledge we can testify to the necessity of this recent decision of the Colonial Secretary, as, in instances we know of, gross faults have been persisted in by the committees of hospitals when making alterations, even, in some instances, when protested against by the medical officer.

LEADING ARTICLE.

IS A CAUSAL RELATION BETWEEN THE BACILLUS TUBERCULI AND TUBERCULOSIS SECURELY ESTABLISHED?

By J. ASHBURTON THOMPSON, M.D. (BRUX.),
SAN. SCI. CERT. (CAMB.).

FROM the second edition of Dr. Klein's work "Micro-organisms and Disease," published a couple of months since, I get the following subject for reflection. I believe it is worth the attention of your readers.

Sattler's assertion that jequirity ophthalmia is due to a bacillus which is found infesting jequirity infusions a short time after they are prepared, and which is the common ferment of decomposition, the bacterium termo, had unusual interest. This bacterium is not able to produce ophthalmia when it is derived from other substances than jequirity infusion; its power to do this appeared, therefore, to be derived from the soil in which it grew, or, in other words, it appeared as though Sattler had made the most important discovery that a non-pathogenic organism can be transformed into a pathogenic organism by suitably altering its medium of growth. Klein, therefore, took up the study of this point and worked it out. The experiments by which he showed that the bacterium termo has nothing to do with the production of ophthalmia are well known. They are quite conclusive; and since they were published Messrs. Warden and Waddell, of Calcutta, have isolated the active principle of jequirity, which is named abrin, and to which the peculiar effects referred to have been shown to be due. But how did Sattler fall into his most interesting error? Klein's explanation is as follows:—The former made his cultivation in solid media, that is to say, in gelatine, which the b. termo liquifies in growing. He inoculated the gelatine with a drop of jequirity infusion, which he made very strong, and allowed to infuse for several days. This drop, by liquefaction of the gelatine, became enlarged; from the latter he took, again, a drop to inoculate a fresh culture tube, and so on. Every one of these cultivations possessed poisonous properties. But Klein found that if from one to two drops of a poisonous infusion of jequirity are added to from 5 to 600 of distilled water, this largely diluted solution is still capable of exerting a poisonous action. Sattler's successive cultivations then, which were carried on for the purpose of isolating the bacillus, and of obtaining a pure cultivation, gave nothing of the kind; they produced a much diluted preparation of the infusion he had started with, which re-

mained strong enough nevertheless to cause its characteristic effect.

The *b. tuberculi* will not grow in fluid media. It is cultivated on solid serum or solid agar-agar peptone. After the cultivation has been kept in the incubator for ten days or a fortnight, at a temperature of from 37°-39° C., small, dry, whitish scales appear, which afterwards coalesce. These consist of the bacilli lying close side by side. New cultures may be established from this first culture, and so on, all the cultures as far as they have ever been carried being able to cause tubercle in animals by inoculation. Klein states that this result, as of course is well known, has now been corroborated by very many different observers in various parts of the world, and he himself apparently agrees in accepting it as proving the causal connection between the bacillus and the disease. He disagrees, however, with Koch, Watson Cheyne, and others, who maintain that each tubercle is due to the immigration of the bacilli, and says that it is not difficult to find tubercles in which there is no bacillus; whereas, in the same section, cheesy tubercles may be present containing numbers of tubercle bacilli.

Is it possible that the conclusions drawn from this method of cultivating the *b. tuberculi* may be subject to the same error by which Sattler's conclusions with regard to the bacterium termo were vitiated? This question Klein does not clearly answer.

REVIEW.

MEDICAL GUIDE TO THE MINERAL WATERS OF ROTORUA.

By T. HOPE LEWIS, M.R.C.S., L.S.A.

(Published by H. BRETT, Auckland, N.Z.)

THE author, after three years residence as Government medical officer at Rotorua, has published the conclusions he has arrived at from his experience there in the shape of a moderate sized guide book, which will undoubtedly prove very useful to the general public, and to members of the profession having patients whom they think are likely to be benefitted by thermal bathing. He gives a list of nineteen springs, seven of which are situated at Rotorua, four at Ohinemutu, one at Te Koutu, three at Whakarewarewa, two at Arekekapakapa, and two at Tikitere. To this list he adds a series of analyses of the water of each which is most interesting, and will be found most useful to professional readers. In addition is a description of an acid mud-bath, with the analysis of its contents. A description is given of the situation, surroundings, means of access and accommodation for visitors to the hot springs. The diseases which he has found most benefitted by the thermal treatment in them are rheumatism

(chronic, muscular and articular), gout, rheumatic gout, sciatica, lumbago, some diseases of women, which he does not specially mention in this book, —written more especially for the general reader— dyspepsia and obesity, and, finally, diseases of the skin. He enters into useful and interesting particulars as to the best methods of application, gives practical hints as to exercise, clothing and diet, winding up with a description of the climate, and best routes to take to get there. We recommend our readers, and others interested, to procure the book and study it for themselves, believing that it will be a useful source of desirable information. We trust that the author may, at some future date, be able to send us a series of cases treated there, compiled from clinical notes made on the spot, as a guide for the judgment of medical practitioners in colonies distant from New Zealand, when choosing cases likely to be benefitted by the hot springs of what we think must ultimately become the sanatorium of the southern hemisphere, if not of the greater part of the world.

NEW REGULATIONS AFFECTING MEDICAL ATTENDANCE AT LOCKUPS AND ELSEWHERE AT THE REQUEST OF THE POLICE IN N. S. WALES, WHICH CAME INTO FORCE ON JUNE 10, 1885.

Ordinary Visits.

Legally qualified medical men will be allowed a fee of ten shillings for each visit in ordinary cases, to include all necessary medicines, dressing, &c.

Minor Operations.

For minor operations, a fee of one guinea.

Capital Operations.

For capital operations the account will be paid after reference to the Medical Adviser to the Government, if considered reasonable.

Fees at Night.

Double fees on ordinary visits will be allowed at night, i.e., between 10 p.m. and 5 a.m.

Fees for Examination and Evidence, &c.

The fee for examination and evidence in lunacy and other cases will be one guinea, and where two or more cases are heard on the same day, half fees only will be allowed after the first. The charge for attending and examining the prisoner in the lock-up will be included in the fee of one guinea.

Mileage.

Mileage from the medical man's residence to the place where the patient is seen will be allowed at the rate of five shillings per mile beyond the first up to five miles, and seven shillings per mile for each mile above five up to twenty-five. Four miles by rail to be equal to one by road. Cases occurring above twenty-five miles to be submitted for the determination of the Medical Adviser to the Government.

Accounts.

The accounts to be rendered to the police quarterly, and to specify the dates of the service, the names of the patients, and the nature of the complaints, with a special explanation justifying more than one visit to a patient in any one day.

In cases where more than one patient is medically attended during a visit to a lock-up or other place, only half fee for each visit after the first is to be charged, and no mileage; this is not to refer to operations.

OBITUARY.

CHARLES GOSSE, M.D. ET CH.M.,
ABERD., M.R.C.S.E.

It is our painful duty to record the death of Dr. Charles Gosse, Honorary Ophthalmic Surgeon at the Adelaide Hospital, and one of the best known medical men in South Australia, who died at his residence, North-terrace, Adelaide, on July 1, at the early age of 86 years. His decease is the result of a buggy accident he met with on Monday, June 29, when one of his ankles was severely fractured, and, gangrene having set in, it was decided by the members of the medical profession in attendance that the only hope was to amputate the injured leg at the thigh. This operation was performed on July 1, but Dr. Gosse never rallied afterwards. He slowly sank, and expired shortly after 8 o'clock in the evening.

The deceased gentleman was the youngest son of the late Dr. William Gosse, and was a native of the colony. He was born in Adelaide on December 26, 1849, and his father having destined him for the medical profession, he was, at a comparatively early age, sent to England to pursue his studies. After a preparatory course of education at Clifton School, Bristol, he removed to London, to be trained for the profession; afterwards he filled the position of House Physician to the Charing Cross Hospital, and House Surgeon to the Royal Westminster Ophthalmic Hospital, also Clinical Assistant at Moorfields' Ophthalmic Hospital, and there he gained most of his medical experience. In 1870 he received the diploma of M.R.C.S., England, and then proceeded to Aberdeen, where, in 1872, he passed as Master in Surgery, and took the degree of Bachelor of Medicine. In 1875 he secured the degree of Doctor of Medicine. During the whole of his career at these establishments, Dr. Gosse paid special attention to the diseases of the eye. Immediately on his return to the colony, in January, 1873, he became associated with his father in his practice, and on May 26, 1876, he was unanimously appointed, on the resignation of his father, to the position of Honorary Medical Officer of the Adelaide Hospital, and on September 16, 1881, it having been deemed advisable to place the ophthalmic cases under special treatment, he was appointed Honorary Ophthalmic Surgeon for five years, which appointment he held to the time of his death. He was also appointed a member of the S. A. Medical Board in the latter part of 1884. He was a Fellow of the Royal Society of S. A., and had just completed his term of office as Vice-president and President of the S. A. Branch of the British Medical Association. At the Hospital

he endeared himself to the patients by his constant kindness and attention to both in and out-patients, and many in all parts of South Australia will be thankful to remember the skilful treatment received at his hands. He also took great interest in the Medical School now being initiated at the Adelaide University, and was one of the sub-committee appointed for the preparation of rules for the admission of medical students to the Hospital. In October, 1884, he opened the Gosse wing of the Home for Incurables—an institution in which both he and his late father took the deepest interest. He was a prominent member of the Adelaide Literary Society, at whose meetings he was latterly a constant attendant. He took part in the discussions, and gave valuable contributions, especially upon medical and scientific subjects. The busy life led by him as a medical man prevented him from taking an active part in public matters, although he had every inducement to do so. He left a widow and one little girl. His funeral was the largest on record, and attended by professional and official friends and prominent citizens. His Excellency the Governor sent his carriage, and the judges were present.

EDWARD BARKER, F.R.C.S., ENG.,
M.D., MELB.

DR. EDWARD BARKER, of 53, Latrobe-street, East Melbourne, whose death took place at Beaconsfield-parade, St. Kilda, on June 30, was an old colonist, having come to Victoria in 1840. He did not at first practice his profession, but, like several other medical men who came hither at that epoch, he took up land, and successfully applied himself to pastoral pursuits. In 1849, however, he came to Melbourne and commenced practice, and soon acquired an extensive and lucrative connection. In 1851 he was elected surgeon of the Benevolent Asylum, and in the following year he was chosen as one of the honorary surgeons of the Melbourne Hospital, a connection he retained for 23 years, during which period he became deservedly celebrated as a skilful operating surgeon. When the medical school of the University was founded in 1862, he was appointed Lecturer on Surgery, an office he held until 1880. He was one of the founders of the Medical Society of Victoria, and shortly after its commencement became its president. For some time past his health has been very infirm, and the prosperity which marked his early experience in this colony has declined. His death makes another break in the fast diminishing list of those who constituted the medical profession in the primitive era of Victoria. Dr. Barker had two sons, also in the profession, both

of whom died during the last eighteen months, one of them quite recently. Mrs. Barker's death also occurred only a few weeks ago, and it is well known that these bereavements depressed him very greatly, and tended to hasten his own decease. He became a Member of the Royal College of Surgeons in 1839, and a Fellow in 1859; he also took the degree of M.D. of the University in Melbourne in 1863. The deceased gentleman was a Member of the Medical Board of Victoria, and an official visitor of the Sunbury Lunatic Asylum, and prior to his leaving England for the Colonies, he held the position of House Surgeon at the University College Hospital, London. He was a native of Buckinghamshire, England, and was in his 68th year.

**ARTHUR ANNESLEY WEST, M.D. ET
CH.M., DUBL., F.R.C.S., IREL.**

It is with great regret that we have to record the sudden death of Dr. Arthur Annesley West, of Sydney, at the early age of 37 years, which sad event took place on June 28. Dr. West was about his practice on the day before, and left for his private residence, Ardenode, Parramatta River, at 3.30 p.m. When near Ryde he became unwell, but was able to reach home, where everything in the shape of medical skill and careful nursing was procured, but all of no avail, the cause of death being internal hæmorrhage. Dr. Rowling, of Parramatta, and Dr. Goode, of Sydney, were with him. He leaves a widow and five children to mourn their loss. Dr. Arthur Annesley West was the second son of the late Mr. George White West, J.P., of Ardenode, county Kildare, Ireland. He graduated at Trinity College, Dublin, in 1869, when he took the degree of M.B. He then came out to Australia, and practised at Raymond Terrace, Hunter River. In 1877 he returned to the old country, and obtained the degrees of M.D., M.Ch. (T.C.D.), and became a F.R.C.S.I. Then he returned to Sydney, and started practice at the Glebe, where he remained until his death. He held the position of honorary physician to the Sydney Hospital for several years, and was also one of the honorary physicians to the Hospital for Sick Children, Glebe Point, but had to relinquish both appointments owing to increase of private practice. Dr. West was also an active member of the New South Wales Board of Health.

BIRTHS.

DE VIS.—On June 16, at her residence, 54 Newtown-road, Sydney, the wife of Chas. J. De Vis, M.R.C.S., Eng., &c., of a daughter.

HAON.—On June 26, at North House, Sunnyside, Christchurch, N.Z., the wife of W. E. Haon, L.R.C.P., Lond., M.R.C.S.E., of a daughter.

THE MONTH.

NEW SOUTH WALES.

A MEETING of the conjoint Board, consisting of the Senate of the University and the Directors of the Prince Alfred Hospital, was held on June 22, when the following resolutions were unanimously carried, at the suggestion of the Chancellor:—1. "The conjoint Board of the Prince Alfred Hospital, consisting of the Senate of the University and the Directors of the Hospital, having this day received an official notification of the death of the late Dr. G. Fortescue, desire to express their deep sense of the loss sustained by the Hospital and by the University, and to record their appreciation of his earnest and faithful services to the Hospital as its senior honorary surgeon, and of his readiness also to promote the advancement of medical education in the University School of Medicine. 2. The conjoint Board desire also to convey to the widow of Dr. Fortescue the expression of their cordial sympathy with her in her great bereavement. 3. That a copy of the above resolutions be forwarded to Mrs. Fortescue."

At the last meeting of the Senate of the Sydney University, a report was received from the Faculty of Medicine, recommending adoption of the suggestions made by the lecturer in pathology, that he should be appointed curator of the Pathological Museum, and pathologist at some hospital or hospitals, and that, if possible, the facilities afforded by both the Prince Alfred Hospital and the Sydney Hospital should be utilized by the Senate for the purposes of pathological instruction. The report was adopted.

THE Directors of the Prince Alfred Hospital have made the following appointments:—Hon. physician, Dr. Murray Oram; hon. surgeon, Dr. Hankins; assistant hon. physician, Dr. David Collingwood; assistant hon. surgeon, Dr. Alex. McCormick.

THE new hospital for the mining district of Bombala has just been completed, and will soon be ready to receive patients.

A PUBLIC meeting of representative citizens was held at the Sydney Town Hall, on June 24, for the purpose of impressing upon the Government the necessity for the early introduction of a "Public Health Bill." The principal resolution agreed to was proposed by the Primate, seconded by Sir William Manning, and supported by Dr. A. Renwick, and reads as follows:—"That having regard to the insanitary condition of the city and suburbs, this meeting considers it absolutely necessary that the Government should take immediate steps for submitting to Parliament a comprehensive bill to provide for the preservation of the public health."

A SERIES of ten weekly lectures will be delivered this winter in the Sydney School of Arts by the following honorary lecturers: Mrs. Garrett Anderson, M.D. of London, who has chosen "Education" as her subject. The other lectures of the series will comprise:—"Typhoid Fever," by Dr. E. J. Jenkins; "Personal Hygiene," by Dr. Scot-Skirving; "Exercises and Training," by Dr. Knaggs; "House Sanitation," by Dr. W. H. Goode; "Diseases of Children and the Prevention of Infectious Disease," by Dr. C. Dagnall Clark. The lectures are intended for women (married and single) and the elder classes of girls' schools. The entire proceeds will be devoted to the purposes of the Home for Nurses.

AT a meeting of the friends and supporters of Drs. John Harris and Stapleton, held at Newcastle on June 26, it was decided that the following requisition be

sent to the superintendent of the A. A. Company's Colliery, in order to bring the present complicated affairs in connection with the miners and medical attendants to a termination:—"We, the undersigned, most respectfully request you will not stop any money earned by us, employees of the A. A. Company, towards paying Dr. Baker."

DR. GIBBONS, of Lithgow, and his wife, had a narrow escape on July 3, while driving a buggy on the Bowenfels-road. A goods train which was passing at the time frightened the horse, and caused it to bolt. The buggy, which came in contact with a post, was capsize, and the occupants were thrown out with great violence. Mrs. Gibbons received a severe shaking.

DR. F. A. POCKLEY has commenced practice at North Shore, a suburb of Sydney.

DR. A. W. EDDIE, of Bombala, desires us to state that he has not removed to Bendoc, in Gippsland, as mentioned in our May issue, but that he is still practising at Bombala as hitherto.

DR. C. N. SIMONS, of Wagga Wagga, has exchanged practices with Dr. R. B. Warren, of Brighton, suburban to Melbourne.

DR. J. J. STAPLETON, of Armidale, has removed to Newcastle.

NEW ZEALAND.

AT a meeting of the medical profession held in Christchurch, on June 11, the largest meeting ever seen in that city, sympathy was expressed with Dr. Stewart under the attack made upon him in the *Wellington Evening Press* on May 21st. The opinion was expressed that the article was malignant, scandalous and untruthful, and that Dr. Stewart should at once commence an action against the *Evening Press*. It was resolved to forward the resolution passed to the Government. We may add that all the medical men resident in Christchurch and district were present at this meeting, with the exception of Dr. Nedwill, the moving spirit in the hospital dispute, and his next door neighbours, Drs. Doyle and Frankish.

IN THE Legislative Council, on June 19, it was resolved, on the motion of the Hon. Colonel Brett, that the papers relating to the Christchurch Hospital scandal be laid on the table. The Colonial Secretary remarked that they were of a lively character.

DR. C. G. SATCHELL, of Richmond, has removed to Takaka, near the coast, 60 miles N.W. of Nelson.

DR. ALFRED STEVENS, a freeman of the City of London, has settled at Tauranga, on the Bay of Plenty, 180 miles S.E. of Auckland.

DR. T. B. WHITTON, now of Reefton, has resigned his commission as Honorary Surgeon in the Southland Hussars.

QUEENSLAND.

THOMAS GREAVES, M.R.C.S., Eng., 1881, L.R.C.P., Lond., 1882, late of Ivy Depot, Virginia, U.S.A., who commenced practice at Warwick a few weeks ago, died very suddenly on June 24, while visiting one of his colleagues in town. He was quite a young man and not long married. It is supposed that he died from heart disease.

DR. W. E. RAMSDEN WOOD, late Assistant Medical Officer at the Bethlehem Royal Hospital and Resident Physician Assistant at Middlesex Hospital, London, has commenced practice at Rockhampton.

SOUTH AUSTRALIA.

AT a meeting of the board of management of the Adelaide Hospital, held on July 10, Dr. H. S. Lloyd was appointed junior house surgeon. A graceful tribute was paid to the memory of the late Dr. Gosse, and the valuable services he rendered to the hospital. A resolution was carried that a letter of condolence be sent to Mrs. Gosse.

A MEETING of the friends of the late Dr. Chas. Gosse, presided over by the Chief Justice, was held at the Adelaide University on July 6. It was decided that it was desirable to establish a fund for a memorial to perpetuate the memory of Dr. Gosse, and an influential committee was formed. £150 was subscribed in the room.

DR. JAS. COCKBURN, M.H.A., has been appointed Minister of Education in the new Ministry formed by Mr. J. W. Downer.

DR. E. F. COOPER, a new arrival, has commenced practice at Morphett Vale, in a wheat-growing district, 15 miles S. of Adelaide.

DR. F. W. ELLISON, late of Forest Hill, London, has commenced practice at Adelaide.

DR. ROBERT SMITH, late of Yarrowonga (Vic.), has settled at Penola, near the Victorian Border, in the midst of a large pastoral district, 259 miles S. E. of Adelaide.

TASMANIA.

THE Government are about to introduce a Health Bill based on the lines of the Act in force in Melbourne.

VICTORIA.

THE Lunacy Commission at a meeting on July 9, decided to visit Sydney for the purpose of inspecting the asylums there, where very great improvements have been made under the auspices of Dr. Norton Manning, Inspector-General of the Insane, and of taking the evidence of two well-known (?) experts in that colony. A letter was ordered to be sent to the New South Wales Government asking permission for the Commission to visit the asylums. The Commission also decided that a representative from each Victorian asylum should be elected by the attendants to express and represent the views entertained by the attendants as to what organic changes are required for the better government of these institutions.

AT a meeting of the Central Board of Health, held on June 12, a letter was read from Senior Warder Coffey, of Maryborough Gaol, mentioning that he had often shot over the Plenty Ranges, including the watershed of the Yan Yean, and had found tapeworms in opossums and native bears. He thought the matter worthy of investigation in connection with the Yan Yean water supply. Mr. Newbery stated he could corroborate the statements, and thought the subject worthy of further investigation. He suggested that Professor M'Coy, or his taxidermist, might be able to give valuable information. It was agreed that inquiries should be made, and the subject further considered at a future meeting.

AT a meeting of the Central Board of Health, held on June 26, a letter from the Chief Secretary's Department, Adelaide, referring to the medical inspection of the mail steamers, was read. A resolution was carried to the effect that the matter was in a very unsatisfactory state, and that the board refuse to recognise any bill of health brought by a vessel from Adelaide unless

signed by a duly qualified medical man, or unless the vessel had a clean bill of health from Albany.

THE foundation stone of a new hospital was laid at Ararat on June 24, with great *clat*. Between 2,500 and 3,000 persons were present. In the afternoon a luncheon took place, which was largely attended, and in the evening a ball was held in the Town Hall. The building will probably cost £4,000. There is already over £1,500 to the credit of the fund, and £1,500 has been promised by the Government.

WESTERN AUSTRALIA.

DR. R. J. LEPPER, late of Mahé (Seychelles Islands), has settled at Pinjarrah, the principal town of the Murray agricultural district, 53 miles S. of Perth. Dr. Lepper has been appointed Resident Magistrate of the district.

DR. CECIL ROGERS has been appointed Captain of the Albany Defence Rifle Volunteers.

CHARLES CHAD TURNOUR, M.R.C.S., Eng., 1875, L. et L. Mid. R.C.P., Edin., 1879, Government Medical Officer for the Swan district, died at Guildford on July 1. The deceased gentleman was formerly assistant house surgeon at the Leicester Infirmary, England.

MEDICAL APPOINTMENTS.

Allwork, Frank, L.S.A., Lond., to be a Surgeon in the S.A. Rifle Volunteer Force.
 Birch, Lewis John, M.B., Melb., to be Public Vaccinator for Tarraville, Vic.
 Bennett, Arthur, M.D. et Ch.M., L.R.C.P., Lond., M.R.C.S.E., to be Officer of Health for shire of Dundas, Vic.
 Bruehl, Stewart, M.D. et Ch.D., to be Medical Officer to the Destitute Board for Hawker, S.A.
 Cleghorn, George, M.R.C.S.E., to be Honorary Surgeon to the Blenheim Rifle Volunteers, N.Z.
 Closs, Joseph Osborne, M.B. et Ch.M., Edin., to be Honorary Surgeon in the Southland Hussars, Invercargill, N.Z.
 Ellison, Frederick William, M.R.O.S.E., to be Public Vaccinator for Adelaide, S.A.
 Fish, Robert, M.R.C.S.E., to be Honorary Surgeon to the Geraldine Rifle Volunteers, N.Z.
 Fussell, Ernest, L.S.A., Lond., to be Honorary Surgeon of the Woodville Rifle Volunteers, N.Z.
 Hayden, James Augustus, M.R.C.S.E., to be Health Officer for shire of Dimboola, Vic.
 Hogg, Richard Bowen, M.R.C.S.E., to be Honorary Surgeon of the Timaru Rifle Volunteers, N.Z.
 Irving, James, M.D., Edin., M.R.C.S.E., to be Honorary Surgeon of the Canterbury Mounted Rifles, N.Z.
 Jordan, Thomas Furneaux, M.R.C.S.E., to be Health Officer for Borough of Sebastopol, Vic.
 Lepper, Robert John, L.R.C.P. et R.C.S., Ed., to be Resident Medical Officer of the Murray district, W.A.
 McKee, James Charles, L.R.C.P. et R.C.S., Edin., to be Public Vaccinator for Raywood, Vic.
 Murphy, William Patrick, M.B. et Ch.B., Melb., to be Resident Assistant Medical Officer at the New Norfolk Asylum for the Insane, Tas.
 Owen, Frederick James, M.D. et Ch.B., Melb., to be an additional Public Vaccinator for North Fitzroy, Vic.
 Parker, Alfred Henry, L.R.C.P., Edin., to be Medical Officer to the Destitute Board for Mannum, S.A.
 Poulton, Benjamin, M.D. et Ch.B., Melb., M.R.C.S.E., appointed Senior House Surgeon to the Adelaide Hospital, S.A.
 Stothell, Charles George, M.R.O.S.E., to be Public Vaccinator for the Takaka District, N.Z.

Smith, Edward Robert, M.R.O.S.E., to be an additional Public Vaccinator for the District of Cowra, N.S.W.

Smith, Robert, L.R.C.S., Edin., to be Medical Officer to the Destitute Board for Penola, S.A.

Watson, Arthur, M.D. et Ch.M., Edin., to be Public Vaccinator for the Popotuna District, N.Z.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW ZEALAND.

Stevens, Alfred, M.R.C.S., Eng., 1883; M. et L.S.A., Lond., 1886.

Teevan, Henry, M.R.C.S.E., L.S.A., Lond., 1881.

QUEENSLAND.

Lucas, Thomas Pennington, L.R.C.P., Edin.; L.S.A., Lond., 1870; M.R.C.S., Eng., 1871.

Brown, Samuel, M.B. et Ch.M., Edin., 1876.

Greaves, Thomas, M.R.C.S., Eng., 1881; L.R.C.P., Lond., 1882.

Rogers, William Henry, L.S.A., Lond., 1877; L.F.P.S., Glas., 1882.

White, Thomas George, L.R.C.S., Irel.; L. et L. Mid. K.Q.C.P., Irel., 1877.

SOUTH AUSTRALIA.

Ellison, Frederick William, M.R.C.S., Eng.; L.S.A., Lond., 1878.

Giles, William Anstey, M.B. et Ch.M., Edin., 1882.

Cooper, Ernest Frederic, L.R.C.P., Lond.; M.R.C.S.E., 1875.

Smith, Robert, L.R.C.S., Edin., 1881; L.A.H., Dubl., 1880.

TASMANIA.

Byrne, Hugh John, L.R.C.S., Irel., 1882; L. et L. Mid. K.Q.C.P., Irel., 1882.

Murphy, William Patrick, M.B., 1884; Ch.B., 1885, Melb.

Haines, Hugh Gough, L. et L. Mid. R.C.P. et R.C.S., Ed., 1883; F.R.C.S., Ed., 1886.

VICTORIA.

Gay, Herbert Moultrie, M.B. et Ch.M., Glas., 1882.

Salter, George Herbert, M.R.C.S., Eng., 1882; L.R.C.P., Edin., 1882.

Walsh, George Joseph, L. et L. Mid. R.C.S. et R.C.P., Edin., 1880.

Wright, Robert, L.R.C.S., Irel., 1882; L. Mid. R.C.S., Irel., 1883; L. et L. Mid. K.Q.C.P., Irel., 1883.

Additional qualifications registered:—Frederick James Owen, M.D., Melb., 1885; William Moore, M.D. et Ch.M., Melb., 1886.

WESTERN AUSTRALIA.

Kenny, Daniel, L.R.C.S., Irel., 1883; L. et L. Mid. K.Q.C.P., Irel., 1884; L. Mid. Ocombe Lying-in Hosp., Dub., 1884.

Lepper, Robert John, L.R.C.P. et R.C.S., Edin., 1877.

CORRESPONDENCE.

A CORRECTION.

(To the Editor of the A.M.G.)

SIR,—On page 219 of present number of *Gazette*, the last two lines of my remarks on Dr. Collingwood's cases are not correctly stated. It should read "Agreed with Dr. Skirving against resection being usually found necessary."

"Where the necessity did arise, he was not aware of any special difficulties in its accomplishment."

I think it would be well to correct the error, as you will observe I stated the opposite to what appears.

Yours truly,

CRAIG DIXSON, M.D., F.R.C.S., Ed.
 Hyde Park, Sydney, June 23.

REPORTED MORTALITY FOR THE MONTH OF MAY, 1885.

Cities and Districts.	†Population.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from							
				Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Child-bearing.
N. S. WALES.											
Sydney	103,379	205	62	...	2	3	...	7	10	30	2
Suburbs	120,832	310	152	...	5	13	1	27	17	14	3
NEW ZEALAND.											
Auckland	28,313	25	12	...	...	...	...	2	4	2	...
Christchurch	16,387	17	3	...	1	...	...	1	...	...	1
Dunedin	24,895	18	4	...	...	1	...	...	...	2	...
Wellington	22,933	33	17	...	...	...	...	3	...	3	...
QUEENSLAND.											
Brisbane	26,557	...	...	*	...	...	...	...	...	...	...
Suburbs	9,612	...	...	...	...	...	...	...	...	...	...
SOUTH AUSTRALIA.											
Adelaide	318,816	334	137	...	...	13	2	15	22	25	1
Adelaide	43,969	70	20	...	...	1	...	2	1	9	...
TASMANIA.											
Hobart	28,931	40	14	3	...	2	...	4	1	8	1
Launceston	18,173	26	9	...	...	1	...	1	4	2	...
Hospitals, Asylums, Gaols, &c. .	1,211	29	...	...	...	...	...	...	...	...	...
Country Districts.....	85,422	54	...	1	...	...	1	...	3	...	...
VICTORIA.											
Melbourne	65,791	73	176	...	1	6	2	29	16	73	2
Suburbs	238,618	453									

* The Official Monthly Report on the Vital Statistics of Brisbane and Suburbs does not show the number of deaths from the various diseases.
† The population of N. S. Wales, Victoria, Adelaide, and Queensland, is that of the census of 1881; New Zealand, South Australia, and Tasmania show the estimated population at the present date.

METEOROLOGICAL OBSERVATIONS FOR MAY, 1885.

STATIONS.	THERMOMETER.				Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.		Depth.	Days.		
						Inches			
Adelaide—Lat. 34° 55' 33" S. ; Long. 138° 36' E.....	...	80·6	60·7	42·	30·037	...	...	...	...
Auckland—Lat. 36° 50' 1" S. ; Long. 174° 49' 2" E.....	124·	65·5	56·2	40·	...	4·640	19	73	...
Brisbane—Lat. 27° 28' 3" S. ; Long. 153° 16' 15" E.....	146·	86·	66·7	46·5	30·262	1·21	8	76	N.E.
Christchurch—Lat. 43° 32' 16" S. ; Long. 172° 38' 59" E.....	...	...	...	...	...	...	...	...	...
Dunedin—Lat. 45° 52' 11" S. ; Long. 170° 31' 11" E.....	100·	61·	46·4	35·	...	1·622	17	79	...
Hobart—Lat. 42° 53' 32" S. ; Long. 147° 22' 20" E.....	...	70·8	52·2	35·7	29·956	·89	14	77	...
Launceston—Lat. 41° 30' S. ; Long. 147° 14' E.....	...	66·7	50·7	30·	30·056	2·65	9	82	...
Melbourne—Lat. 37° 49' 54" S. ; Long. 144° 58' 42" E.....	...	75·	54·6	41·2	30·074	1·24	17	...	...
Sydney—Lat. 33° 51' 41" S. ; Long. 151° 11' 49" E.....	...	77·3	60·	46·2	30·207	0·21	5	66	NW.
Wellington—Lat. 41° 16' 25" S. ; Long. 174° 47' 25" E.....	116·	62·	51·5	38·	...	5·179	25	88	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

CASES OF LIGHTNING STROKE.

READ BEFORE THE MEDICAL SECTION OF THE
ROYAL SOCIETY OF NEW SOUTH WALES.

By EDWARD J. JENKINS, M.A., M.D., OXFORD, M.R.C.P., M.R.C.S.E., &c., LOND.,
MEDICAL SUPERINTENDENT, PRINCE ALFRED
HOSPITAL, SYDNEY.

SOME members now present may remember that on a former occasion I exhibited two patients who had been struck by lightning. The cases excited great interest at the time, and an animated discussion followed, and it was generally desired that further observations should be made, and that a more detailed account of the accident, and the symptoms following it, should be given. This, therefore, is my excuse for reading this paper to-night; and though I am conscious of the fact of the existence of many imperfections, yet I hope the details recorded may, anyhow, prove not uninteresting. On the afternoon of October 21st, 1884, three men, Alfred Mills, Frederick Matchett and another, ran to a brickshed in a brickfield, not far from the Newtown Railway Station, to take shelter from the rain, during a severe and sudden thunderstorm; all were more or less wet through, and on arriving at the shed they crouched down, near one of the central posts supporting the roof of the shed. The roof was of galvanized iron, but the sheets of iron did not meet exactly, and there was a space two inches wide all along the top, admitting rain. Two dogs were lying down near the men—suddenly, there was a vivid flash of lightning, immediately followed by a terrific crash of thunder. All three men were knocked over, the dogs took to their heels and escaped unhurt. The man, who crouching in the centre, between the others, though stunned for the moment, soon recovered himself, and found Mills and Matchett on either side of him, both insensible. No visible damage was done to the shed, and the man was too excited and unnerved to notice whether the earth had been cast up in the neighbourhood. Before proceeding I may add that I went to the scene of the accident myself and examined the surroundings carefully. The man in the centre had a post exactly behind him, and this post was slightly splintered on each side, the central part being uninjured, otherwise the building was intact. Mills and Matchett were at

once conveyed to the Prince Alfred Hospital, and on the way Matchett recovered sensibility. At the expense of being wearisome, I will now give you a short account of each patient. Alfred Mills, aged 19; occupation, brickmaker; admitted on the 21st October, 1884. When first seen he was in a state of extreme collapse, skin cold and cyanotic, face pallid, pupils dilated, and pulse weak and running; could give no account of the accident. The only external injury was a wound on the back of the head, at the junction of the apex of the lambdoidal with the sagittal suture, circular in shape, and about the size of half-a-crown; it presented the appearance as if the patient had been branded with a hot iron. Being in such a serious condition he was kept in the Casualty Room, and stimulants were forced, and warmth applied in the form of hot-bottles, and mustard plaster over heart. In a short time he became strongly convulsed, foamed at the mouth, and became rather cyanosed. The muscular contractions were clonic, and lasted about twenty minutes, when he relapsed into his former condition; temperature normal. After removal to the ward he again had convulsions, and early in the morning got out of bed, and for the first time muttered something, but was not sensible. Later on in the day he answered when spoken to, and complained of headache, but remained stupid and drowsy, and passed all under him. On the 23rd, condition much improved, and he stated he had no pain, but merely a feeling of numbness and tingling all over; no paralysis, sensation fairly good, and ophthalmoscopic examination revealed nothing abnormal. 25th—The wound at back of head sloughing, discharge offensive, temperature 101°, headache. 26th—Slough came away, and bare bone exposed; still complains of numbness of hands, but can walk well with eyes shut; reflexes normal, as also electrical reactions. From the 26th till November 1st he continued to improve, and on that day a circular piece of bone was removed from wound at the back of the head. November 6th—Wound rapidly healing, is now able to help in the wards, and take plenty of exercise, is still obtuse, but he never was brilliant. From the 6th to December 30th he continued to improve, and no new symptoms were manifested, and on January the 5th he was discharged, feeling as well as ever.

Frederick Matchett, brickmaker, aged 26, admitted on October 21st, 1884. When seen at the Hospital was in a dazed state, but was able to give some account of himself, and remembered everything up to the time of the accident. At the back of the head, in almost exactly the same

position as in the case of Alfred Mills, was a circular patch of the size of half-a-crown, and presenting exactly the same appearances; the hair was all burnt, and the smell of burnt hair was very perceptible; beyond a general feeling of numbness, felt fairly well, and had no pain, and was able to walk, though with difficulty; pulse 84; temperature 101° ; pupils natural. No marks on the body;—no injury to clothing except the hat, in the crown of which was a small hole not larger than a pin's head, and there was a distinct smell of burning about it. 26th—Temperature 103° , due to sloughing and inflammation at the seat of injury. Patient got out of bed, and for the first time the great inco-ordination of muscular movement was noticed, and it was remarked by Dr. Fortescue that the movements were so irregular that they might truly be denominated choreiform. 27th—Pulse 102, temperature 103° , much headache, bowels open, feeling of numbness and tingling increased; inco-ordination as yesterday; patellar tendon reflex, markedly increased, the slightest tap on the tendon produces knee jerk at once; no ankle clonus; scrotal and abdominal reflexes not more than usual; sensation, good. Patient can tell exactly where he is touched, even when the contact is made with a feather; no deafness, tinnitus, or loss of taste or smell; no actual paralysis. Patient cannot walk along a fixed line, and has difficulty in standing with eyes shut, or when his heels are brought together. Can distinguish at once between hot and cold; no hyperæsthesia; no want of control over sphincters; no abnormal electrical reactions. Ophthalmoscope reveals nothing abnormal, and the vision of both eyes is good. November 5th—The slough at the back of the head came away, and the bare bone is exposed. December 2nd—Inco-ordination still great. Patient cannot walk except with a stick; no fresh symptoms; piece of bone removed.

Patient was discharged on January the 5th much better, but still unable to walk without crutches. Since then he has been gradually improving, and can now walk some distance unaided, but finds it necessary to use a stick, and must concentrate his attention on his movements. His complaint is, that if he looks at any object in motion, whilst walking, he at once becomes giddy and unsteady, and feels as if he would fall over. The patella tendon reflex is still excessive; but still he feels stronger, and is not aware of any change in his mental condition. His memory never was brilliant, and his education has been sadly neglected, for he can neither read nor write, and his spare time is passed by over indulgence in the use of tobacco.

Comparing the cases, the chief points of interest seem to be:—

1. The fact that the man in the centre at the time of the accident escaped unhurt. His back was quite close to the post which was injured, and possibly the post being a better conductor than himself might help to explain matters. He is rather shorter than the injured men, and his clothes were of similar material, and equally wet. It is a well known fact that wet clothes are better conductors than dry clothes, and that there is a different conducting power in different kinds of clothes. This capricious action of the discharge has been noted before. Thus in June, 1871 (see Taylor's Med. Jurisprudence, Vol. ii., p. 134), a coachman was killed, and the footman sitting by his side escaped injury. The lightning struck the coachman on the head, destroyed his hat and rent his clothes—it passed through his body—tore a large hole in the cushion on which he was sitting, and, except shattering the glass, did no injury to the carriage, nor to those inside.

During the same storm three men were mowing in a field. They put down their scythes and sought shelter; but as they were leaving the field they were all three struck down—only one was killed. It was found he was struck on the right side where he wore a steel chain to his watch.

Another case of interest, and resembling in some points the Newtown cases, is to be found in the *Lancet*, July 31, 1864. Three persons had taken shelter under a hay stack, when they were struck—the hay stack was set on fire. A boy, aged ten, had difficulty in moving his legs at first; pain in the abdomen and red streaks on the chest. He was well in four days. A boy, aged 11—the shock was more severe; he had epileptiform symptoms and similar red streaks; whilst his hair was singed at the back of the head and neck. He became conscious in five hours, and rapidly recovered. No. 8, a man aged 46, was killed on the spot. Rigidity came on fourteen hours afterwards. He had a lacerated wound of the scalp, dividing blood vessels and nerves. His hair was singed, his knife was magnetised, and his clothes, which were wet, were not torn.

In another case—*British Medical Journal*, August 3, 1872—two men were struck by lightning whilst taking shelter under an oak tree; one man suffered from shock. There was loss of power in the lower extremities; recovered next day. The other was unconscious for ten minutes; had collapse and widely dilated pupils; hair singed; current diverted by watch chain, and watch, which was quite destroyed. Partial paralysis; eventually got quite well.

In another case—*British and Foreign Medical Review*, October, 1842—three persons were struck by lightning. One of them, aged 26, an hour and a half after the stroke, lay insensible as if apoplectic. His pulse was 60; pupils dilated;

respirations noisy ; had severe spasms ; body drawn to left side He recovered consciousness in 24 hours, and soon got well.

Another case of interest is quoted in *Medical Times and Gazette*, November 1, 1879. A man was standing under a tree which had been struck by lightning. His boots lay at the foot of the tree, whilst his clothes were scattered in a line for several yards along the field ; the man himself was stretched on his back six feet away, stark naked, and calling for aid. He says he felt himself violently struck across the chest and shoulders, hurled through the air, and dashed upon the ground, but is sure he never lost consciousness. He was more or less burnt all over. The os-calcis was fractured, and there was a compound comminuted fracture of the right tibia and fibula. He showed no signs of shock, and recovered perfectly.

2. The second point of interest is the fact that in the case of Alfred Mills—the symptoms at first were so alarming and serious—the unconsciousness followed by severe convulsions and extreme collapse, pointing to great shock to, and disturbance of the nervous system. The convulsions were epileptiform in character, and it would be impossible to localise the injury to any particular part of the central nervous system. The symptoms of shock rapidly passed away, and the patient made excellent recovery, and now feels stronger than ever.

3. The third point of interest is that in the case of Frederick Matchett. The symptoms at first were comparatively slight and unimportant, but they were followed by symptoms showing great and lasting impairment of the nervous structure, as evinced by the striking want of muscular co-ordination and the remarkable increase of the deep reflexes, and particularly the patella tendon reflex. There seems to have been a great shock, not only to the central nervous, but also to the spinal system, producing, probably, a molecular disturbance of both the sensory and motor nervous elements, rather than an inflammation followed by sclerosis. I was at first inclined to believe that a descending degeneration was taking place along the motor tract, proceeding from the cerebral cortex to motor centres, and along the "crusta," and then down the crossed and direct pyramidal tracts. For, it is generally agreed that exaggeration of the reflexes is due to disease of the lateral columns, and is usually associated with secondary degeneration ; but disease of the lateral columns usually produces exaggeration of both forms of reflex—the superficial and the deep—whereas in cerebral lesion the deep are exaggerated, but the superficial are diminished or abolished. Now, in the

case of Matchett, the superficial are certainly not exaggerated, and so it is possible that little or no spinal disturbance has taken place, but that the symptoms are entirely due to cerebral disturbance, and that the increased tendon reflex is due to the fact that the usual inhibitory impulses are not passing down the cord. Then, again, the seat of the injury is in the immediate vicinity of the cerebellum, and the function of the cerebellum is undoubtedly that of exercising a persistent co-ordinating and regulating influence over volitional movements, so that the extreme want of co-ordination, to a certain extent, may have been due to disturbance of the functions of the cerebellum. It seems to me impossible, however, to localise the lesion, and the concussion must have been fairly general. The sensory perceptive centres certainly were implicated as shown by the feeling of numbness and tingling all over, but especially of the fingers.

With the exception of the inco-ordination, the increased reflexes, and the feeling of numbness, all other symptoms in the case of Matchett are negative—absence of headache, eye changes, impairment of sight, hearing, smell or taste ; no actual paralysis, no rigidity or loss of tone, no trophic disturbances, no girdle pains, hyperæsthesia or paralysis of sphincter ; and it merely remains to add that the patient is daily getting stronger, and so the prognosis should be favourable. Another point of interest is as to the direction of the current ; was it a descending, or was it an ascending or return stroke ? Dr. MacLaurin was of opinion that the accident was due to the return stroke. In these cases the clouds near the earth are negatively electrified, whilst the earth is positively, and the human body serves as the conductor by which the equilibrium is restored. In connection with this point Dr. Manning gave me a good example of the damage done by the earth current of lightning on or about January 12th, at Gladesville. He states, "during the storm, a bushy young camphor laurel standing in a square, and surrounded by buildings, some of them of considerable height, was struck. The very bushy top was not touched, and is as green as ever, but the lightning evidently came up from the ground ; it threw up the earth all round the trunk, which it split in two, and escaped in six or seven places, all about one height, in the smaller branches, where the bark was peeled off and the wood splintered, all the splinters pointing upwards, and showing conclusively the course of the lightning. The smell of camphor (I suppose set free by the heat) was, for a time, very strong. The tree, so far, though much damaged, shows no signs of dying."

And from a medico-legal point of view the case of Matchett is interesting, and shows how, in

severe concussion as, e.g., in railway injuries, serious symptoms may not show themselves till some time after the accident; and also there can be no doubt that excessive ignorant and indiscriminate use of galvanism may lead to unfortunate results. The effects of lightning also may simulate those of foul play. An interesting account of the post-mortem appearances in a case of death from the action of electricity, by Marmaduke Sheild, may be found in *The British Medical Journal* for September, 1884. The man was killed in the electrical department of the "Health Exhibition." A very clear account of the "Lightning" stroke, as regards forensic aspect, can be found in vol. 1 of "Legal Medicine," by Meymott Tidy. He quotes 54 cases, and of these 21 died and 33 recovered.

Experiments with the induced spark by Dr. B. W. Richardson, in 1869, were conducted, and he came to the conclusion that:

1. Lightning kills by an intense shock like that of a Leyden jar.
2. That the fatality is in proportion to the intensity.
3. That the kind of covering with which the body is furnished makes a great difference. "Furs and feathers are protective."
4. That in people who recover, the reception of the shock is not remembered. It is probably the most painless of deaths—hence judicial use, and for killing animals.
5. That those discharges, which from their intensity, kill most readily, leave fewest and least marks of external injury.

"Arago" states that when lightning strikes men or animals near each other, its action on the extremities is most severe. And "Taylor" states "It is worthy of note that of three or more persons together, one or two only may be struck."

As regards best position to take up in a storm:

1. Dangerous under a solitary tree.
2. Where the trees are in clumps, not so dangerous.
3. Hay-rick bad, for if dry it is a worse conductor than the body.
4. Open country bad, for the person is the only object of attack.
5. Recumbent is the safest position.

In conclusion, gentlemen, I may add that both the patients struck are here to-night, and you will see that Matchett is still suffering from muscular weakness, and that the patella tendon reflex is still exaggerated. He informs me that before the accident he was a constant sufferer from headache, but that since he has been quite free. I hope that members better able, and more experienced than myself, will throw some light on the obscurer symptoms.

A CONTRIBUTION TO THE STUDY OF HEREDITY.

(READ BEFORE THE MEDICAL SECTION OF THE ROYAL SOCIETY OF N.S.W.)

By F. NORTON MANNING, M.D.,

INSPECTOR-GENERAL OF THE INSANE
IN N. S. W.

Some time ago I commenced an enquiry into the family and life history of the idiotic and imbecile patients in the Hospital for the Insane, at Newcastle, with the view of ascertaining the cause of the malady under which they were suffering, and especially how far hereditary mischief had a share in its production. I was soon met by a difficulty which had not occurred to me, in the impossibility of tracing the relations and friends of a large number of the patients. On searching the records, a very considerable proportion were found to be deserted children, who had been picked up as waifs by the police, and after a short stay in the Benevolent Asylum, or some kindred institution, had been sent to find a permanent home at Newcastle. Not long after the opening of the Institution 20 cases were sent in one batch from the Benevolent Asylum, and in no one of these was the address of relatives or friends known. In other instances, it appeared that the children had been sent from home to the Hospital upon the death of the relatives or friends immediately in charge of them, and that other relatives, if such there were, took no interest in them, made no enquiries about them, and did not reply to enquiries concerning them. Out of a total of 220 imbecile and idiot patients on the register in July, 1884 (I am excluding the demented and aged epileptics), the address of friends was known in only 140 cases, or less than two-thirds. As I had to gain such information as I required mainly by correspondence with people probably far from well educated, possibly not over bright in intellect, and certainly subject to all sorts of prejudices and fancies, I soon abandoned the task I had set myself. Baffled in the larger and more comprehensive enquiry, I turned to the cases in which there were two or more of a family afflicted with mental weakness; cases which possess a peculiar interest as more likely to be constitutional and congenital in origin, than accidental.

The result of the enquiries made I now propose to place before you, and I may state at the outset that, though far from as complete as could be wished, they have involved some labour and trouble, and in some cases necessitated the intelligent and confidential assistance of the police, through the courtesy of Mr. Fosbery, the Inspector-General. From 21 families, with a

total of 82 children—48 males and 34 females—I found under care 50 idiot and imbecile children—29 males and 21 females. Two families had 4 imbecile children each, four families had 3 each, and the remaining 15 had 2 each, receiving asylum treatment and care, whilst other members of these families, remaining at home, were reported as feeble minded. I have divided these 50 children into 4 groups.

The first of these I may dismiss at once with the statement that it contains 6 individuals—4 male and 2 female—from 3 families; that all, though under hospital care, are imbecile* in a comparatively slight degree; and that the only information I could obtain was they were the only children of their respective families. No information was obtainable as to the cause of the imbecility, the consanguinity of parents, or the insanity or neurosis of relatives.

In the second group are 3 children—2 boys and a girl—all imbeciles of a low grade. They belong to a family of 3 boys and 5 girls—and the mother writes as follows:—"The cause in the first boy was my getting a sunstroke whilst pregnant; the second boy was afflicted through my being thrown from a horse whilst pregnant; and the girl from my helping my husband to fall a tree whilst pregnant. All the other children are sound in intellect. My husband and myself were in no way related, neither of us have been subject to fits, and, as far as I know, none of our people (my husband's relatives or my own) were subject to insanity or weak in mind." The letter is well written, and apart from the fancies as to causation, strikes one as that of an intelligent woman. Some further enquiries served to establish the fact that no near relatives—that is, either brothers, sisters, father, or mother—of either parent had been insane. Little or nothing was known of the grandparents and uncles and aunts of the parents, and it is possible that hereditary influence might have been ascertained could further information have been obtained. As the matter stands, we have three badly imbecile children in a family of 8; no known—certainly no close—hereditary influence, and no marriage of near kin, and the group is as you will see, in these respects, exceptional.

In the third group are 26 children—11 males and 15 females—all imbecile or idiotic, and belonging to 12 families, in which, up to this time, the total number of children is 44—25

males and 19 females. Unhappily, some of these families are still increasing; but, so far, we have 11 out of 25 males, and 15 out of 19 females, so far imbecile or idiotic as to need hospital care. Of the mental condition of the children not under care I have no means of judging, but I have information that 4 are badly deformed, one is a dwarf and is being exhibited as such in a show, and 8 have supernumerary fingers and toes.

In none of these 12 families, so far as I can learn, are the parents closely related, but in all there are insane relations, more or less close, and in 5 of them there has been a veritable intermarriage of disease, there being insanity on both sides. In these 5 families there are 18 children—10 males and 8 females, and 12 of these—4 males and 8 females—are imbecile and idiotic; so that two-thirds of the total, and every female are afflicted, and among them are to be found all the badly idiotic patients in this group. In the 7 families in which insanity has been traced only on one side, there are 26 children—16 males and 10 females—and of these 14—6 males and 8 females—are imbecile, the proportion being over a half, and the females, as in the other cases, showing a larger proportion than the males.

I have placed all these cases in a tabular form, showing the insane relations in each. Some of these were peculiar, and of special interest.

In case 5, a paternal uncle and the paternal grandmother, and also a maternal uncle, were insane, and 2 out of the 3 died in Gladesville. In this case the whole family, 4 in number, were idiots of a low type, crippled, and unable to walk.

In case 6, the father was insane and deformed, and the mother was epileptic and occasionally insane. The family consists of 3 children—2 females, both imbecile and one deformed, and 1 male, a dwarf.

In case 8, two maternal uncles were insane, and under care at Gladesville; a maternal cousin is an imbecile at Newcastle, and a paternal cousin was in the same institution. 2 out of 4 children are imbecile.

In case 15, the maternal grandmother was for some time at Gladesville; 5 maternal uncles were incurably insane, and under hospital care, and a sixth maternal uncle had been 4 or 5 times under treatment for short periods. There are 2 children only in the family, and both are imbecile.

The peculiar sympathy which people, who are neurotic, and have a tendency to insanity, feel for each other, often results in marriage. I have, on several occasions, had husband and wife under

* I use the term imbecile when the patients can speak, and idiot when they do not possess this power, and are so far lower in the mental scale. The distinction is a useful and practical one. The degree of imbecility or idiocy, of course, varies much in different cases.

my care at the same time for marked insanity; and the peculiarities of persons who come as visitors to their wives and husbands when patients in hospitals for the insane, are most remarkable, and occasionally lead to the conclusion that the less insane member has been placed under care, and the more insane left at large. Our chairman will remember a case in which he was asked, with me, to give an opinion as to the mental condition of a husband, and in the course of our enquiries we found that two other medical practitioners had been asked some time before to express a like opinion as to the wife; and I can recall more than one similar experience.

I am by no means certain that I have been able to ascertain all the insane relations in these 12 families; indeed, it is highly probable that I have not, for the family tree in this colony exists, for the most part, only in an undeveloped and shrubby state, and the family annals are little subject to correction by the village gossip, or the "oldest inhabitant."

How difficult it is to obtain trustworthy information in these cases may be judged from the fact that, in one case, a mother denied all knowledge of insanity in the family though 4 members were under asylum care, and persistently attributed the mental condition of one of her children to fright, caused by a goose flying over its head when 14 months old.

In the fourth group were 15 children—13 males and 2 females—from 5 families, with a total of 24 children—15 males and 9 females. In 2 cases I was able to ascertain that there was insanity in the family, and in the whole of the cases the parents were closely related. In 2 instances they were first cousins, and in the remaining 3, after patient inquiry made through confidential channels, I obtained convincing evidence that they were, in each instance, brother and sister. In one instance they left England to avoid remark, and accounted for their curious likeness to each other by describing themselves, both on board the ship in which they came to the colony and subsequently, as first cousins, but of their closer relationship there was no doubt. The father died a short time ago, and the mother is bed-ridden from paralysis. Both are described as dull in intellect.

In the second case, a magistrate of the colony writes:—"The man is sober and steady, and the woman who cohabits with him is generally known as his sister. Their mother, now 95 years of age, lives with them, and is feeble both in body and mind, the latter possibly from her great age. Besides the 3 idiot children, there are 4 others—a son and a daughter who are married, and 2 unmarried girls. All of these, as well as the

parents, are more or less simple, and in the children at home mental weakness is quite visible. Humane persons have, on several occasions, sought to take action as regards the parents, but found the law contained no provision for such cases. They are generally avoided by their neighbours, who hold little intercourse with them."

In the third case, the parents are described as uneducated, and below par in intellect and low type.

With the exception of the woman 95 years of age above-mentioned, nothing could be learned as to the grandparents, or other relations, of the children, 9 in number, 8 belonging to each family, who were the product of sexual intercourse between brother and sister. It is somewhat remarkable that the whole 9 were idiots of the lowest type, dirty in habits, unable to utter an articulate sound, and so paralysed and deformed as to be unable to walk.

In connection with these cases, I may mention that Dr. Bemiss (whose enquiries in this direction are well known, and who published a summary of them in the II. Vol. of the "Transactions of the American Medical Association"), obtained particulars of 31 children born in the U.S., of brother and sister, or parent and child, and of these, 29 were defective in one way or another, 19 were idiotic, 1 epileptic, 5 scrofulous, and 11 deformed; and the same enquirer found that of 2778 children born of first cousins, 793 were defective, 117 deaf and dumb, 63 blind, 231 idiotic, 24 insane, 44 epileptic, 189 scrofulous, and 9 deformed.

The question of the full proportion of idiocy and imbecility due to hereditary influence is an interesting one. 41 of the cases I have mentioned appear to be so due, and I have knowledge of 25 other cases in the hospital at Newcastle in which there is family insanity, making 66 cases out of 220, or somewhat less than one-third. If full information could be obtained, I am convinced that almost, if not quite, half of the cases could be traced to hereditary insanity or mental weakness.

The cases of which I have given particulars go towards proving—

1st. That idiocy, in a large proportion of cases, is not an accident, but is due to hereditary influence, and is the result of the natural laws governing this. Of the certainty of these laws, and the importance of their bearing on the facts of human life, we have a full conviction, though we are unable exactly to define their processes; and the pathological action of hereditary influence is as difficult and obscure as the physiological action thereof.

2nd. That cases of direct heredity of imbecility or idiocy are fully as common as those in which

it is transmitted in the collateral or reversional form, which is opposed to the view of Dr. Seguin, a great authority on this subject, who remarks: "I have not, to my knowledge, ever had to attend an idiotic son of an idiot, or even the son of a man of weak intellect, but I have often found in the family of one of my patients an aunt, or much oftener, a grandfather, afflicted with idiocy, or at least imbecility."

3rd. That double heredity is, as might be expected, much more potent than where the taint exists on one side only.

4th. That whilst there is abundant evidence that the chief varieties of mental malady are themselves transmissible, nervous disorders are often transformed in their transmission, and that the metamorphoses of heredity are perplexing. A family, whose head has died insane or epileptic, does not of necessity consist of lunatics and epileptics, but the children may be idiots, paralytics, or scrofulous. What the father transmits is not insanity, but a vicious constitution, which manifests itself under various forms; or to quote Dr. Morel,* "We do not mean exclusively by heredity the very complaint of the parents transmitted to the children, with the identical symptoms observed in the progenitors, but the transmission of organic dispositions; and psychologists have frequent occasions for observing this hereditary transmission and the various transformations which are exhibited in the descendants. A neuropathic state of the parents may produce in the children an organic disposition which will result in mania or melancholy—nervous affections which, in turn, may give rise to more serious degeneracy, and terminate in the idiocy or imbecility of those who form the last links in the chain of hereditary transmission."

5th. That unions between blood relations influence idiocy and imbecility more than they do the acquired forms of insanity, or those which show themselves after childhood.

The 4th group is an interesting one, as tending to raise the question of the influence of consanguineous marriage; but I am inclined to think that the cases in no way militate against the conclusions arrived at by Huth in his elaborate volume on the marriage of near kin, which may be thus briefly stated.

Consanguineous marriages, by the mere fact of consanguinity, and irrespective of any inheritance, are not injurious to offspring, and in the marriage of two relatives, both perfectly healthy, and living under healthy conditions, and whose families are perfectly healthy, the children born will probably be healthy.

In addition to the facts stated in proof of this conclusion in Huth's work I may mention one which has recently come to my knowledge. In 1858 two families named Young, numbering 16 in all, descended from the mutineers of the "Bounty" and their Otaheetian wives, returned from Norfolk Island to their old home at Pitcairn. The children were all first cousins on their father's side, and their parents were all closely related. In 1863 a further migration of the Young family, with a family named Christian, and one individual named Buffet—in all 30 persons—took place from Norfolk Island to Pitcairn, all these being closely related to each other and to the former swarm. In 1882 the number of inhabitants on Pitcairn had risen from 46 to 104, the increase being, with two or three exceptions, due to births on the island; and Captain Bouverie Clark, who then visited the place and specially examined the children at my request, reported that there was no case of idiocy, imbecility, or weakness of intellect, or deformity, among them.

In ordinary life, however, and in ordinary conditions, it is difficult to find persons in perfect health, and with no imperfections, physical or mental, to be transmitted. It is well known that any morbid tendency existing in each parent is transmitted with great certainty, and usually in intensified degree, to the offspring. Relations, of course, must more frequently than strangers, possess the same constitutional condition, and, as has been said, "consanguinity raises heredity to the highest power." It is more than probable that in the cases I have brought under your notice, we have an intermarriage of disease in its worst form. In the cases of incestuous union, all the parents are described as more or less weak minded, and the very fact of their seeking such unions, in the conditions of life as they now are is, in itself, evidence of scant intellectual development and blunted moral feelings.

If I had been able to devote the necessary time to the subject, I should have been glad to discuss the interesting question of the connection between bodily deformity and intellectual defect. Such deformity accompanies idiocy, not only in the shape of paralysis, and the wasting and contortions consequent on this, but in absence, imperfection, or re-duplication of limbs or organs, ranging from simple webbing of the fingers or supernumerary digits to the most hideous malformations. I cannot now, however, enter on this. In 571 cases of idiocy collected by Dr. Howe, 21 were blind and had deformed eyes, 12 were deaf, 23 had deformity of mouth and nose, 54 deformed hands and feet, and 96 were paralysed in some parts; and every asylum for the imbecile and idiotic affords numerous

* *Traité des dégénérescences de l'espèce humaine.*

instances of this kind, which add not a little to the painful aspect of the inmates.

The practical conclusions which we may, I think, draw from the facts I have placed before you are—

1st. That the marriage of persons who are, or have been, insane, or who come of families in which insanity is known to exist in a pronounced form, should—except under special circumstances—be discouraged, as likely, in addition to the dangers of direct heredity and the production

of progeny, apt to develop insanity, to produce idiotic or imbecile children; and

2nd. That the intermarriage of persons from neurotic or insane families, and the marriage of near kin, especially when there is mental peculiarity of any kind, should be discountenanced in every possible way as almost certain to result in insane or idiotic offspring; and that we, as medical men, have a duty to perform in this matter by pointing out the evils likely to result from such unions.

No.	RELATIONSHIP OF PARENTS.	TOTAL NUMBER OF CHILDREN.	NO OF IMBECILE OR IDIOTIC CHILDREN.	INSANE RELATIONS.	REMARKS.
Group 1	1 Nothing known.	2 (1 m. 1 f.)	2 (1 m. 1 f.)	Nothing known	Imbecile only in slight degree.
	2 do.	2 (2 m.)	2 (2 m.)	do.	Do. do. do.
	3 do.	2 (1 m. 1 f.)	2 (1 m. 1 f.)	do.	Imbecile.
		6 4 2	6 4 2		
Group 2	4 None	8 (3 m. 5 f.)	3 (2 m. 1 f.)	None as far as could be ascertained	All badly imbecile.
		8 3 5	3 2 1		
Group 3.	5 None	4 (2 m. 2 f.)	4 (2 m. 2 f.)	Insanity on both sides { Paternal grandmother and uncle, and maternal uncle	Imbecile. All 3 insane relations were in Gladesville, one for 16, and 1 for 22 years.
	6 do.	3 (1 m. 2 f.)	2 (2 f.)		Imbecile. Father cripple, brother a dwarf.
	7 do.	2 (1 m. 1 f.)	2 (1 m. 1 f.)		Imbecile, slightly.
	8 do.	4 (3 m. 1 f.)	2 (1 m. 1 f.)		Imbecile, badly.
	9 do.	5 (3 m. 2 f.)	2 (2 f.)		Imbecile, badly. Both sisters and 3 brothers have supernumerary fingers and toes, 2 of brothers are somewhat weak-minded.
		18 10 8	12 4 8		
	10 do.	6 (4 m. 2 f.)	2 (2 m.)	Insanity on one side only. { Maternal grandfather	Imbecile.
	11 do.	3 (2 m. 1 f.)	2 (1 m. 1 f.)		1 idiotic, 1 imbecile, mother in Gladesville.
	12 do.	2 (1 m. 1 f.)	2 (1 m. 1 f.)		Imbecile.
	13 do.	3 (2 m. 1 f.)	2 (1 m. 1 f.)		Imbecile.
	14 do.	5 (3 m. 2 f.)	2 (2 f.)		Idiotic.
	15 do.	5 (3 m. 2 f.)	2 (2 f.)		Idiotic.
	16 do.	2 (1 m. 1 f.)	2 (1 m. 1 f.)		Idiotic.
Group 4.		26 16 10	14 6 8		
	17 Brother and sister	7 (4 m. 3 f.)	3 (3 m.)	.. .. .	Badly idiotic. Father and mother and remaining members of family described as very simple-minded.
	18 do.	7 (3 m. 4 f.)	3 (2 m. 1 f.)	.. .. .	Badly idiotic. Father a drunkard, mother bed-ridden and paralysed, both described as dull in intellect.
	19 do.	3 (3 m.)	3 (3 m.)	.. .. .	Badly idiotic. Parents described as uneducated, low in type, and below par in intellect.
	20 1st Cousins ..	4 (3 m. 1 f.)	4 (3 m. 1 f.)	Maternal Cousin ..	Imbecile.
21	do.	3 (2 m. 1 f.)	2 (2 m.)	Several Cousins ..	Idiotic. Parents not noticeably peculiar.
		24 15 9	15 13 2		
	Total ..	82 48 24	50 39 21		

TWO CASES OF SPEAR WOUNDS PENETRATING THE CHEST.

BY GASPARO SPELLINI, M.D. ET CH.D., LATE
MEDICAL OFFICER TO THE MAYTOWN HOS-
PITAL, NORTH QUEENSLAND.

First Case.—A Chinaman, Ah Gow, was brought to the Maytown Hospital on April 16, having been speared by the blacks three days before when digging for gold in the bed of one of the Palmer River's branches. A piece of spear was protruding from the left ninth intercostal space on the posterior axillary line. I had to lay open widely the wound's track, and, after some exertion, managed to withdraw the spear, which proved to have been imbedded in the body for fully ten inches; it had an iron point and barb, both made with the same piece of fence wire. The direction of the wound was inward and forward, with a slight inclination upward, and, from the roaring escape of air through it in the movements of respirations, diagnosis of pulmonary perforation was certain. I was sure that the piece of spear which penetrated the chest ten inches must have injured, not only the left, but also the right lung, and might have wounded some other important organ, such as diaphragm, aorta, inferior vena cava, pneumogastric, œsophagus, phrenic nerve, if its direction had been only a little different. Considering the depth of the lesion, it is difficult to conceive another point of the chest where to lodge a foreign body penetrating so far and, at the same time, so little fatal. The external hæmorrhage was very slight. No signs of internal extravasation. No spitting of blood. Breathing frequent, but not accompanied with great oppression. Pulse weak and contracted. For a few days I observed subcutaneous emphysema around the wound; subsequently, dulness of percussion on the posterior and lateral part of left thorax, with bulging of intercostal spaces. After two weeks all these phenomena disappeared, and clear resonance on percussion, with respiratory murmur, were re-established. So far as I could discover, the lung did not for a moment collapse. Strong attacks of fever took place. The discharge from the wound, after having been watery for a couple of days, became purulent, and so great was the quantity of it, that I had to dress the wound

with a large sponge. The visceral cavity was washed out with a syringe twice a day, using for some time a solution of corrosive sublimate (1 to 1000), but after stomatitis having occurred, I used a solution of sulphate of iron, which, besides having an antiseptic action, did good to the patient as a general tonic. Fœtid discharge went on until May 10, when the last piece of necrotic lung was expelled in a fit of cough. After this time the discharge decreased day by day until the beginning of June, when it stopped altogether, and, although the internal cavity showed no sign of being filled up, the external wound was continually shrinking until it quite healed, leaving the patient perfectly well.

Second Case.—This latter case, although a spear-wound of the left lung, similar to the former, did not prove fortunate in its issue, owing mainly to the circumstance that the spear, instead of injuring the lower part of the respiratory organs, injured the higher portion, where all the large branches of the pulmonary blood vessels are running, and consequently the danger of a fatal hæmorrhage is much more to be dreaded.

Whilst on my journey from Maytown to Cooktown, my services were requested for a case of spearing that had occurred at Lalla Rook station, near the Kennedy River. I travelled in that direction as quickly as possible, and met the patient, C. M., at Balser's station, where he arrived after having ridden eighty miles on horseback with a spear in his body. The spear had entered the chest on the left shoulder, just at the level of the armpit, close to the external border of the scapula. When I met the patient on the evening of June 5, he was in a very low state of physical depression, owing to his having been wounded six days before. By a large incision into the subcutaneous tissues, I cut as far as the intercostal space without being able to reach the barb of the spear, which was embedded in the pulmonary tissue. A little traction brought out a piece of wooden spear eight inches in length, yet leaving the barb inside, as I concluded from the presence of a narrow piece of rotten kangaroo skin twisted near the joint. Not having succeeded in extracting the barb with a long forceps, I did not like to use any other means for the purpose, as the hæmorrhage from the lung was rather extensive. Having plugged the wound, I left the patient, who felt much relieved since the spear had been extracted. Next morning the wound was dressed again, and hope began to be entertained of a favourable proceeding, when, a short time before noon, cough with hæmoptysis set in, the pulse disappeared, and in a few minutes the patient was dead, evidently choked by pulmonary hæmorrhage.

CARCINOMA OF THE CERVIX UTERI.

By J. O. CLOSS, M.B. ET CH. M., EDIN., OF
INVERCARGILL, NEW ZEALAND.

As this pathological condition, with its relief or cure, has been exercising the minds of many, both at home and abroad, and while the matter is still fresh in the memory, perhaps another case may not prove unacceptable to the profession.

On the night of the 26th of last September, I was called to see this patient, on account of "loss of blood." On arrival I found the hæmorrhage was connected with the uterus. She was blanched, and could only reply to questions in a low whispering voice; no radial pulse could be felt. I was informed that she had suffered from a sanguineous discharge more or less, and very irregularly for the last nine months; that she had had one child ten years ago; never any miscarriages. There was no appreciable smell about the bed, and no cachexia could be detected, on account of her blanched appearance. I gave her a hypodermic injection of ergotine, ordered other requisites, and deferred examination till the following day, when I found her very much revived. On digital examination per vaginam, I met an irregular friable mass just inside the vulva. The cervix in its immediate neighbourhood was hard and painful to the touch, but nearer the fornices it was softer, more of the normal feel, and gave no pain on pressure, a clear line of demarcation marking the apparently normal from the abnormal tissue. On the rectal examination, the supra-vaginal portion, with the body of the uterus, felt normal. There were no adhesions, and no affected glands could be felt in the neighbourhood.

In the meantime the patient was far too weak for any operative measures; attention was therefore directed to arresting the hæmorrhage and improving the general condition.

In three weeks time, however, she had made such marked improvement as to justify operation.

The advantages and risks of the two operations, viz: amputation of the cervix, or extirpation of the uterus, were laid before her—she chose the former, preferring the latter only if the disease should return.

On the 22nd of last October, the patient being chloroformed, I amputated the cervix as near the level of the fornices as possible, and apparently clear of all diseased tissue. There was considerable hæmorrhage, for which I applied the perchloride of iron and wool, with most satisfactory results. She stood the operation tolerably well. On the second and third days, I removed the vaginal plugs, which gave her some pain; washed out the vagina with carbolic lotion. There was no bleeding, and the wound looked healthy. In

a few days after this and during the healing process, I almost daily applied to the wound some form of caustic, such as nitric acid or liquid crystals of carbolic acid, and sometimes solid nitrate of silver. She made a good and rapid recovery, returning to her household duties feeling quite well. She menstruated normal on the fifth week from date of operation; the wound had healed entirely, and everything looked perfectly healthy.

This condition of good health lasted for the next six months, when she informed me that she was not feeling so well, that she was beginning to dread a return of the disease. She had now an offensive discharge, and occasionally severe pains.

Shortly after this I made an examination, and found that the disease had returned. The seat of the old wound was occupied by an ulcerated mass, the supra-vaginal portion was now hard and painful, the body was enlarged and somewhat firm, but perfectly moveable. There were no adhesions and no enlarged glands, the disease being apparently confined to the uterus. I thought the case a suitable one for complete removal of the diseased organ, at least it was the only thing I could now hold out. She and her friends fully understood the dangers of the operation, and, after a week's consideration, elected to have it performed.

On the 5th May the patient was chloroformed, and the operation performed. A staff was passed into the bladder, and I dissected down on the uterus, through the anterior fornix. When the cervix was freed all round, the uterus was retroverted, the broad ligaments secured with a double ligature, and the uterus cut away. The wound was stitched and a T shaped drainage tube inserted and packed all round with carbolized wool.

She soon rallied from the depressing effects of the operation. A hypodermic injection of morphia was given, and she slept well for several hours. The catheter was passed, a little high-coloured urine was drawn off, there was slight oozing from the vagina. She passed a very good night, taking at intervals some chicken soup or beef tea. Towards the morning she was sick, vomited, and passed urine; temp. 99.4; p. 100, good in volume.

From this she appeared to go on very well up till the afternoon of the third day from that of operation, when she became very restless, complained of pain all over the abdomen, pulse and temp. ran up to 136 and 104.4° F. Acute peritonitis had set in, and had a strong hold of the patient. As the night grew on she rapidly got worse and suffered a deal of pain. The abdomen was very much distended, tympanitic and exquisitely tender. She gradually sank, and died on the following morning.

REMARKS—In performing this operation I adopted the vaginal method, judging from the collected statistics that I would thereby give my patient the better chance of success. Yet, considering the many difficulties I met with during the operation, I cannot but think that in such cases the abdominal method would be preferable. The vagina was very small, scarcely admitting two fingers and the use of the knife. There was scarcely any cervix to lay hold of by the vulsellum without catching the fornices. The broadligaments were short, not permitting the uterus to come within easy reach; the body of the latter was hypertrophied and firm. The posterior segment of the pelvic floor was quite unyielding. During the retroverting process considerable force had to be used, thereby putting a severe strain on the broad ligaments, and adding considerably to the risk of pelvic peritonitis, which might easily spread (and which actually did in this case) to the abdominal peritoneum. When you add to this the difficulty of ligaturing the vessels of the broad ligaments while the uterus is filling up the whole of the available space in the vagina, one can scarcely but come to the conclusion but that the abdominal method would, at any rate, allow the operation to be performed without any stress or strain, and may in such cases give the patient a slight advantage. Nevertheless, many would say that in the face of the statistics we have on this operation, he would be a bold operator who would abandon the vaginal for the abdominal method, even if he saw considerable difficulties in his way. Yet I am inclined to think that if the operation is to be done at all, the circumstances of each case should determine the method of procedure, and no doubt when extirpation is the primary operation, all other things being equal, the vaginal method would be the better.

It might be interesting to know if the difficulties which I have enumerated were aggravated by the primary operation. When I amputated the cervix I could get the uterus much lower than when I extirpated it. As I have said before, there were no adhesions, and the organ in situ was quite moveable. I can easily imagine a contraction upwards, consequent on amputation and during the healing process. The hypertrophy of the uterus was mostly due, no doubt, to the presence of the disease. Therefore, in such cases where amputation of the cervix has been performed, followed by a return of the disease into the body of the uterus, it might be of the highest advantage to know which method would be preferable, or if such are suitable cases for operative measures.

My thanks are due to Drs. Whitton, Macpherson and Low, for their kind and valuable assistance.

A CASE OF TYPHOID FEVER FOLLOWED BY ABSCESSSES.

By W. FRANCIS QUARF, B.A., M.B., GLAS.,
WOOLLAHRA, NEAR SYDNEY.

NOTES have appeared in a recent number of the *B. M. Journal* of cases of typhoid followed by acute and sub-acute periostitis. In connection with these, it seems desirable to chronicle the following case from my own experience.

J. F., a cowherd, æt. 41, living at Waverley, was attacked during the last week of April by typhoid fever. The attack turned out a fairly mild one, the temperatures, delirium, and diarrhœa not being excessive. The fever was falling distinctly, when, on May 28, a small abscess was discovered upon the tendon of the left biceps femoris. Four days later a large swelling developed over the left shoulder blade. Both these abscesses were poulticed and incised: they showed no indications of resorption. From the latter a large quantity of green pus was evacuated, which, on microscopic examination by the Koch-Weigert method, was found to contain only a few of the micrococci so usual in aseptic abscesses. Iodoform dressings and gilt tubes were employed, and the incisions readily healed. Two or three days afterwards a small abscess was found over the tendon of the left peronæus tertius; it was treated like the others. Extreme tenderness and brawny infiltration of the left calf now became evident, and as poulticing brought no pointing, a deep incision was made between the gastrocnemius and the true peronei muscles, and a large quantity of pus evacuated out of the substance of the soleus muscle. The character of the pus was as before. The incisions all healed readily under the use of tonics, stimulants, and good diet, and there have been no indications of septicæmia.

It may be remarked that the patient is naturally a strong, healthy man, and that at no time during the fever was any affection of the heart, or any albuminuria discovered, or other organic derangement beyond the usual bronchitis, &c.

Two of the abscesses seem, without doubt, to have been upon the sheaths of tendons; the situations of the other two were most probably truly intra-muscular. Abscesses have been found *post-mortem* in typhoid cases in the connective tissue between muscles with tolerable frequency, but evidence goes to show that muscular abscesses, truly so called, are quite rare. Attention has been called to a degeneration and friability in the muscle fibres after this fever, and it is suggested that small hæmorrhages, arising thus, may become converted into pus, though why this conversion should take place, instead of resorption,

is not made clear. The firm, muscular development of the patient in question somewhat favours this view. It seems probable, however, that in this case, as in some of abscesses after pregnancy, and as Dr. Affleck has suggested with respect to his cases of periostitis after typhoid, the cause may be more immediately a lowered nutrition of the tissues. The unilateral character of the abscesses is also worthy of remark.

Reference may here also be made to a case of double hip joint disease after typhoid, of which I have record, in which, as in most of these cases, the patient has since quite recovered his health. The febrile symptoms had quite disappeared when the inflammation came on first in the left hip; it was allowed to go on till disorganization and dislocation upon dorsum ensued. The other hip was fortunately treated earlier. In this case the patient had a fairly strong constitution, and there seemed to be no predisposing cause why these joints in particular should be thus affected.

CASE OF COMPOUND DEPRESSED FRACTURE OF SKULL—REMOVAL OF FRAGMENTS OF BONE—SUBSEQUENT INCISION OF DURA-MATER — HERNIA CEREBRI — DEATH ON THE 20TH DAY—AUTOPSY.

By ALFRED LONDON, M.D. (LOND.), ADELAIDE.

J. C. K., æt. 7, was admitted into the Adelaide Children's Hospital, on April 21st, 1885, with severe injuries to the head, supposed to have been inflicted by a kick of a horse. He was suffering somewhat from shock, but was quite conscious, and not complaining of pain; the pulse was but slightly irregular, though accelerated; the pupils were equal, and reacted to light; he was able to pass urine voluntarily, and to ask for drink, and there was no paralysis.

At noon (four hours after the accident) he was placed under the influence of ether by Dr. Verco, and examination revealed a severe compound, comminuted depressed fracture of the vault of the skull on the right side; the scalp wound was about three inches in length, almost linear and vertical in direction; the contused posterior edge, together with a portion of the underlying temporal muscle, and numerous fragments of a straw hat, was firmly tucked in beneath the skull; the fractured portion was of oval shape, with the coronal suture as its long axis, and posteriorly was depressed to the depth of a quarter of an inch; it consisted of several fragments, all more or less tightly wedged in. After releasing

the soft structures and slightly enlarging the lower angle of the wound, the detached fragments were extracted, some with considerable difficulty, and all foreign matter removed from between the skull and the dura mater, which was seen to be bleeding from a punctiform wound, probably inflicted by a sharp spicule of bone; the surrounding edges of bone were denuded of periosteum, but were allowed to take their chance of recovering. The wound was carefully cleaned with boracic acid lotion, and the scalp brought together with horse-hair stitches, a drain of catgut being laid on the dura mater, and the head was dressed with gauze. He was very sick during, and subsequent to, the operation, but there was no blood in the vomit—dried blood was, however, noticed in the right ear and both nostrils, but there was no oozing of cerebro-spinal fluid.

He regained complete consciousness after the operation, and the sickness soon passed off; he slept well, took his nourishment well, and did not complain of pain or headache, but twitchings were noticed in both upper limbs during the first night. Febrile symptoms soon set in, though the wound remained aseptic, but the temperature was somewhat controlled by cold sponging every two hours. On the 3rd day his consciousness began to be impaired, and during the next two days he became increasingly drowsy, although his temperature ranged considerably lower; his pulse was less frequent, but more irregular; he could put out his tongue, but would leave it protruded—it was thickly coated, but generally moist; his bowels were opened when necessary by means of an enema. From the 5th to the 8th day, he continued to be drowsy, but, in addition, exhibited great irritability when moved or examined; he would lie with half closed eyes, waking up suddenly with the "hydrocephalic cry" or calling querulously for whatever he wanted, and frequently uttering the most piercing screams. He now complained of his head aching, and during the 6th and 7th days had, at frequent intervals, convulsions of the left side of the face and left limbs; the right 6th nerve was also paralysed.

At first the wound appeared to be doing well, but a faint line of slough appeared, and all the stitches were removed on the 6th day; the wound gaped and showed the dura mater, coated with a dense layer of lymph, and bulging through the gap in the skull. The wound was now dressed with iodoform, and frequent doses of chloral and bromide of potassium administered with a view of controlling the convulsions. On the evening of the 7th day, Dr. Way saw the child with me, the temperature had shot up, the convulsions were increasing in severity, and the dura mater seemed almost to be fluctuating; incisions with a tano-

tome were therefore made in three places, and from the upper two, some puriform fluid escaped, probably broken-down brain matter; the tension was relieved and the finger seemed to be depressed into a cavity on the surface of the brain. The next day he had left hemiplegia, and the convulsions gradually ceased; he was very noisy, but less conscious, and a hernia of the brain had already commenced. The rest may be briefly told: the hemiplegia gradually passed off, but now both 6th nerves were paralysed, and the eyes moved asynchronously. Emaciation set in and proceeded rapidly, the noisiness was replaced by gradually increasing coma, the hernia cerebri daily increased in size, and the temperature inclined to rise, and was finally $105^{\circ}-6^{\circ}$. He died on the 20th day.

Autopsy.—The head only was examined; and I have here a portion of the skull showing the fracture, and the right half of the cerebrum. The fracture measures $2\frac{1}{2}$ inches by $1\frac{3}{8}$ inch; the inner plate is shattered beyond the limits of the fracture of the outer table, and at both angles are fragments which are depressed, but were not detected as such during the examination. Posteriorly, an organised clot is seen adherent to the skull. On opening the dura mater, there was no excess of fluid in the arachnoid cavity; the dura mater was adherent to the brain round the neck of the fungus, but nowhere else. A patch of thick, buttery lymph was seen just below the hernia in the sylvian fissure, and very small deposits were also found on the left side of the brain in the sylvian fissure, and on the left side of the under surface of the cerebellum, near the median line, underneath the pia mater. The fungus was about the size of a walnut, and on section it appears to consist of brain matter. There is a zone of chronic inflammation seen around its origin, but no cavity or sign of supuration. There was no fracture of the base.

Remarks.—With regard to the fracture, it is seen that as is common, the inner table is more extensively injured than the outer, but the injury is limited to the area to which the force was directly applied. No lines of fracture radiating from it to the base of the skull. By the light of post-mortem examination it is evident that the depressed portions at the angles of the fracture should have been removed, but they were not detected at the time. The chief point to consider is—was the incision of the dura mater good surgery? It is stated that abscess in the brain substance does not form till from two to three weeks after the receipt of an injury; on the other hand, there might have been a localised collection of pus under the dura mater, which was very tense and bulging.

COMPOUND DEPRESSED FRACTURE OF SKULL—REMOVAL OF PORTIONS OF BONE.—RECOVERY.

READ BEFORE THE S.A. BRANCH B. M. A.,

BY W. GARDNER, M.D., GLAS., ADELAIDE.

Fred. Thompson, æt. 6, who is now exhibited before you, is the patient who was operated upon.

March 13, 1885.—Said to have been kicked by a horse at 3 p.m.; admitted at 8.30. A gaping clean cut wound, about $2\frac{1}{2}$ inches long, at right side of forehead, at bottom of which the frontal bone can be seen fractured and driven in about half an inch.

The child could be roused on admission; the right hand was flexed at wrist, and twitching; also seen to a slight extent in left hand. When in bed spasms ceased. Pulse slow and irregular. Pupil of right eye dilated, and left somewhat contracted.

7 p.m.—Under ether, Dr. Gardner removed the depressed fractured pieces of bone, without trephining. About 12 fragments, of various sizes, were removed. A rent about half an inch long was seen in the dura mater. The wound was dressed with oiled lint and a pad of wool.

There was considerable bleeding from the diploe and wound in dura mater. Child rallied after operation, and for a short time was rather restless, struggling with nurse. Vomited several times. Temp. 97.7 ; pulse slow and more regular. Both pupils contracted. Twitching of hands ceased.

1 a.m.—Child quite sensible; says he was not kicked by a horse, but fell from the roof of a house.

14th, 9 a.m.—Quite sensible; has been crying for his parents. Pulse 94, faint, regular. Urine required to be drawn off. Wound dressed—looking well.

8 p.m.—Temp. 101; child quiet; sleeps well; takes his milk.

15th.—Sensible and quiet, but occasionally irritable. Urine again drawn off at mid-day—passed voluntarily at night.

March 15th.—Some twitching of hands. Enema followed by action of bowels.

16th.—Wound looks well. Passed a good night. Temp. 100 to 101. Slight convergent strabismus, left; is quiet, but cries occasionally for his parents when absent. 9 p.m.—Catheter.

17th.—Doing well. Brain substance protruding through wound in dura mater.

18th.—Slept well; hernia increasing; slight strabismus; pulse 98.

20th.—No bad symptoms; strabismus not noticed; hernia increasing; gentle pressure ap-

plied; colic; a purgative draught given, followed by relief.

21st.—Hernia still increasing, and pulsating distinctly.

23rd.—Wound closing; the hernia compressed by strapping, and dressed with salicylic wool; general condition favourable.

April 13th.—To get up, hernia having subsided and the wound healed.

15th.—Hernia pulsates again markedly. To remain in bed.

R.—Arg. Nit. grs. xx.

Aq. dest. ʒi.

Ft. lot. to be used daily.

27th.—Almost completely healed; no pulsation visible when lying down, but to be felt plainly on pressing the finger into the somewhat depressed cicatrix.

28th.—Discharged.

The temperature was at its maximum on the third day, when it was 101.4°.

THE INSANE POPULATION OF NEW ZEALAND.

DR. GRABHAM, Inspector of Asylums in New Zealand, has favoured us with a copy of his third annual report upon the state of the lunatic asylums of the colony, and upon other matters relating to insanity. It shows that on the 1st January, 1884, there were under detention 1,375 lunatics, and that at the close of the year this number had risen to 1,452. The increase of 77 persons here shown compares very favourably with the corresponding numbers of 106 and 93, which represented the increase of the two previous years, when the population of the colony was considerably less, and when such an annual accession of insanity could not but be regarded as unaccountably and alarmingly great. The proportion of the insane (under detention) to the population of the colony is almost the same now as it was one year ago, viz., 1 to 390 persons.

The insane under treatment at the close of the year were thus placed: Auckland, 820; Ashburn Hall (licensed house), 15; Christchurch, 348; Hokitika, 100; Napier, 16; Nelson, 95; Seacliff, 362; and Wellington, 196: or 1,452 in all. The total number of patients treated in these asylums during the past year amounted to 1,768; and of these, 222 received their discharge, 106 of which had recovered, 26 were relieved, and 80 were not improved. 92 patients died during the year, or 6.53 per cent. calculated upon the average number resident.

The principal causes of insanity were—hereditary, 58; drink, 45; religious excitement, 17; congenital, 13; love affairs, 13; masturbation, 13; and puerperal state, 13. As regards their native countries, 499 hailed from England, 419 from Ireland, 257 from Scotland, 29 from Germany, 21 from Sweden, 19 from Denmark, 18 from Australia, 18 from China, 109 were natives of New Zealand (including 15 Maories), and other countries contributed 63. Of the 1,452 patients under detention at the close of the year, 460 were between 40 and 50 years of age, 392 between 30 and 40 years; 220 between 50 and 60 years, and 219 between 20 and 30 years. The total cost per patient was £29 17s. 5d., against £26 6s. 2½d. in the previous year. The amount collected during the year for maintenance of patients was £4,735 6s. 10d., or £3 11s. 2½d. per head.

ASSOCIATION INTELLIGENCE.

VICTORIAN BRANCH.

MELBOURNE, WEDNESDAY, JUNE 17.

The President, Mr. Rudall, in the chair.

CORRESPONDENCE.

Letters were received: (1) From Mr. C. A. Cramer, visiting justice of Warrnambool gaol, relative to an application he had made to the Chief Secretary, that a receiving house for persons charged with lunacy should be built in that town; (2) From Mr. James Thompson, transmitting the copy of an address delivered by H.R.H. The Prince of Wales to the Commission for the Colonial and Indian Exhibition; (3) From Messrs. Bocke, Tompsitt & Co., with samples of malt coffee.

The following paper was then read:

NOTES ON SOME POINTS IN THE TREATMENT OF ACUTE PROSTATITIS.

BY LOUIS HENRY, M.D.

It is with some diffidence and hesitation that I have the temerity to approach a subject such as the treatment of Acute Prostatitis, as the literature which is in existence on the diseases of the prostate, although not large, is considered to be exhaustive; while the writers and investigators have attained the position of undoubted authority against which it might possibly be considered presumptuous to add to, or say anything in opposition to their treatises. But, as the subject of this paper is "Notes" and not a "Treatise," and as it only professes to be an enquiry suggested by an experience in a small number of successful cases of acute prostatitis, I hope to receive some indulgence from you in response to this effort.

The prostate is ordinarily regarded, anatomically speaking, as a gland. This is, however, not correct, for it is composed largely of smooth unstriated involuntary fibres. The proportion of its construction is as three of muscular to one of glandular elements. Its muscular part is continuous with the sub-mucous layer of the bladder and enters into the formation of the trigonum. The white opaque thread-like forms excreted with the urine are the casts of the ducts of the prostate in some forms of irritation.

A fibrous capsule envelops the gland, and it is in this tissue that abscesses are originated. A large plexus of veins, into which the dorsal vein of the penis enters, is contained in this capsule. The nerve supply comes from the prevertebral hypogastric plexus. The prostatic part of the urethra is the widest, the ejaculatory ducts open into the urethral part of the gland, and orchitis occurs from the fact of the inflammatory conditions

proceeding to the ejaculatory ducts, thence to the vesiculæ seminales, and lastly to the vas deferens. The mucous membrane of the urethra is continuous into the bladder, and is very unyielding over the trigonum and neck, and extremely sensitive, reacting strongly in inflammatory conditions.

The neck of the bladder is, in fact, attached to the prostate, and is, so to say, a part of it.

When an inflammation of the prostate takes place, or rather in the earlier stages of a simple congestion, we get, as a rule, an implication of nearly all the adjoining parts, an irritable bladder, painful micturition, perinæal pains, pubic pains, pains in the back, and possibly constitutional symptoms, such as rigors and fever. After a time the symptoms assume a more aggravated form. A frequency of micturition, with excessive spasmodic pain, at the end of the act is noticeable, the urine undergoes a change in colour and density, it becomes opaque, a white cheesy mass sometimes is ejaculated at the end of the act, and often chemical analysis shows albumen. On examining the rectum, the prostate is felt to be swollen, hot and tender, and on pressure intense pain darts along the penis.

I will in few words attempt to give you a résumé of the few cases that came under my immediate notice, and which have led up to the particular treatment I wish to introduce to you.

A.B., aged 28, full habit, florid, weak circulation, sedentary pursuits, condition of genitals very relaxed, suffers from occasional involuntary diurnal seminal emissions, and frequent nocturnal ones; has been complaining for some time of a slight urethral discharge of a gleet character. As treatment of a tonic kind gives no benefit, he permits a prostatic syringe to be passed to the neck of the bladder and solution of nitrate of silver of 12 grs. to the oz., and later on of 3 grs. to the oz. is injected. The reaction set up by this cauterising fluid passes off in a few days and leaves the patient in a better frame of mind, while doing little if anything of good to the local conditions. Encouraged by the psychological reaction he frequently resorts to these powerful injections with this result, that a most severe form of spasmodic irritability of the urinary tract takes place. The desire to micturate is frequent, the urine scalding and mixed with blood, mucous, and a creamy looking substance; the end of the act of micturition is excessively painful, bringing on spasms of the most violent kind which last for a very long period. In this stage the patient was treated by the book forms of treatment, that is to say, warm hip baths, linseed drinks, the decoctions and infusions of *triticum repens*, *buchu*, *pareira brava*, *uvæ ursi*, *altheæ*, the application of 12 leeches, &c., occasional dose of opium or morphia; the result was a very slight abatement of the attack. The

symptoms at times became easier, but would again, without any apparent cause, assume the acute form.

The patient in this particular instance, at different periods of his illness, got complete retention of urine, so marked that a soft catheter had occasionally to be introduced in order to relieve him. The symptoms, which up to this had confined themselves to the urethral parts, now began to affect the bladder, the urine became turbid, loaded with mucous and mucus pus, showing the symptoms of acute cystitis. After a time even this became aggravated and the participation being shown of the kidneys by the finding of albumen in the urine.

At this stage the patient was advised to take Turkish baths, and for 14 nights he underwent the procedure, without that relief that one would expect from such active treatment. In the course of time, something like five months, the symptoms gradually disappeared.

My second case occurred in the same individual, who, after twelve months of comparative health, brought on himself the same fixture by a repetition of his irritating procedures. In this second attack his urine was from the first characteristic of cystitis. Tired after six weeks confinement in bed and seeing no marked abatement of any symptoms, the paroxysms of spasm being most severe, he determinedly placed himself under the influence of morphia in such a manner that for two days he was almost unconscious of what was going on around him. On his immediate supply of morphia suppositories and opium pills running out, he came completely to himself, and, in his own words, "I awoke on the second morning without a pain, without a spasm, and my urine as clear as crystal."

Another case is that of B. C., who also by means of the same causes as the preceding one brought on himself, was equally long under treatment with little benefit. In addition to the forms of internal administration already mentioned, he received very fair doses of the mercurial bichloride without in any instance, even after prolonged treatment, experiencing any benefit. In this particular case the illness wound up into hydrocele, which, even twelve months after the attack and after frequent tapping, shows a tendency to return.

My fourth case is that of a labourer, who showed all the symptoms of acute prostatitis, whom I was called to see about the fifth day of the attack. I at once, on satisfying myself of the nature of the attack, ordered twelve leeches to the anus, a hip bath and the internal administration of linseed, infusions and alkalies, and what is the principal point, a $\frac{1}{2}$ gr. morphia suppository every four hours until the patient became markedly somnolent. After taking six suppositories the spasms completely relaxed and the urine was clear.

A discharge from the penis continued, however, for some weeks afterwards.

M. P., a bus driver was treated by a chemist for gonorrhœa, with the result that he came to me with all the symptoms of prostatitis. He was treated as in the foregoing, with a similar result.

In these few cases I have attempted to show you that no matter what the irritating cause may be, either strong injections, gonorrhœa, cold, or the use of instruments, the treatment I have found most successful and rapid, in fact at times acting like a charm, is the very free administration of opium both by the mouth and per rectum.

I believe that the earliest application of this treatment will prevent the formation of abscesses, and avoid much complication, such as cystitis and nephritis. The opinion that forces itself on me, is the similarity in many respects that exists between affections of the prostate, and of the female organs of generation. The spasmodic paroxysms of the prostate and urethra correspond to similar conditions of the uterus and vagina, and need not necessarily be induced by inflammation or acute congestion. The treatment that I have adopted for the ailment I am discussing, is one that has recommended itself to gynecologists for treatment of similar conditions in the female sex.

It has often been a matter of some obscurity to me why the prostate and its surroundings should be one of the most, if not the most, sensitive points of the whole body.

I have already pointed out how the local application of caustic as the mere passing of a metallic instrument will, without affecting any change in the pathological features, cause a psychological effect. It is also a matter of experience that the passing of an instrument may bring on an attack of syncope, and possibly death, while again in each instance there is no physical lesion to satisfactorily account for symptoms of such severity; we have, therefore, to deal with a part whose neuropathic history is still a very open and disputed one. According to Treves, the pelvic plexus of the sympathetic supplies the pelvic viscera; this also supplies not only the vaso motor nerves for the blood vessels, but also the mucous and muscular parts of the bladder, rectum, urethra and prostate. From the distribution of the branches of the gangliated cord of the sympathetic and of the prevertebral plexuses, it will be seen that this nerve is especially associated with the blood vessels, the thoracic and abdominal viscera. Minute ganglia and plexiform nerves and small gangliform collections of nerve cells, are very truly distributed amongst the nerves, acting as centres of reinforcement and communication to the solar

plexus and cerebro spinal system. When the urinary tract is affected, the pudic and sciatic nerves transmit sensations to the thigh, buttock, penis and perineum, and the pain at the end of the penis in prostatic affections is explained by the fact that the prostatic nerve plexus, supplying both the neck of the bladder and the gland, is continued to the end of the penis as the cavernous plexus. The nerve itself ends at that very spot where the pain is felt most, namely, the posterior part of the gland. The nerve relations between the anus and neck of bladder are again very closely associated.

The testicle is also, by means of the spermatic plexus which comes from the renal, intimately allied with the kidneys, as shown by the pain felt over the kidneys in affection of the testicle. By means of the renal plexus the testicle is brought into direct communication with the semi-lunar ganglia and solar plexus, which explains the great collapse often noticed in sudden injuries to the testicle, and especially the marked tendency to vomit in such cases.

And the shock which produces syncope by the intrusive insult to the prostate and neck of the bladder, is of a similar kind and origin to the severe symptoms that is associated with a sudden crushing of the testicle on account of the very intimate relationship with the great nerve centre of the abdomen.

I have purposely introduced these nerve relationships and distributions for the purpose of its very suggestiveness, and because I have never seen these points even hinted at as playing any part either in the pathology or the treatment of affections of these parts.

A conversational discussion followed, in which the President remarked that such cases as Dr. Henry had stated were not uncommon. He had gathered from Dr. Henry that the treatment recommended consisted in rest, suppositories, leeches, and opiates.

DR. HENRY: Placing the patient completely under the influence of morphia.

THE PRESIDENT (continuing): But cases with acute symptoms sometimes subside within 48 hours even without opiates, others, however, being much more obstinate. Ordinarily, diluent drinks and leeches or cupping relieved the symptoms, without having recourse to heroic measures. At the same time he saw no objection to the opiate treatment. As to the neurotic manifestations spoken of, he could not speak of any death occurring from shock through the operation of remote plexuses. Fatal effects certainly sometimes come from sudden impressions on the solar plexus, but in such case the cardiac connection was to be borne in mind. He remembered a case of death from shock through drinking ice-cold water, the patient being at the time much heated, and the explanation in that case was the cardiac connection. So far as the prostate was concerned, its remoteness from the plexus concerned would be likely to render the effect less considerable.

DR. HENRY observed that in the case he had related, the symptoms, previously acute, were at once controlled by the morphia, the explanation being that a condition of nervous reaction in the part was produced, giving rise to albuminuria.

The PRESIDENT (continuing) said, that unless the albumen were in large quantity he could hardly suppose that a vaso-motor cause was the explanation of the symptoms, for even when the kidneys were unaffected there was sometimes a little albumen in the urine. Consequently, the necessity of caution in giving an opinion in these cases was evident. In reply to Dr. Henry's remark that death had been occasionally caused by catheterization, he observed that sometimes catheterization of the lachrymal canal, especially in women, was followed by fainting.

DR. HENRY wished to add that he had been supplied by Mr. Guilfoyle, the Director of the Botanical Garden, with the flowers of the *Spiraea Minaria* ("Meadow Sweet" or "Queen of the Meadows") an infusion or decoction of which—an ounce to a pint—he regarded as an excellent drink in prostatitis.

DR. NEILD said that some years ago Baron Von Mueller had set apart a portion of the Botanical Gardens for the cultivation of medicinal plants, and he regretted that this branch of public gardening had not been systematically pursued.

The PRESIDENT, on this subject, referred to the readiness with which Baron Von Mueller had supplied him with the Jequirity, and observed that since he had read his paper on the use of this plant, it had been much employed.

THE LUNACY COMMISSION.

A conversation took place upon the Progress Report of the Lunacy Commission, and the evidence recently given by the Chief Secretary, who had counselled the placing of the asylums under lay-superintendence, an advice which met with general condemnation.

It was resolved to defer further action until a future occasion, when, if necessary, a special meeting might be called to deal with such matters as might arise in connection with the Commission.

VICTORIAN BRANCH.

TUESDAY, JULY 7.

SPECIAL MEETING.

HALL OF THE ROYAL SOCIETY.

The President, Mr. Rudall, in the chair.

The President announced that the Meeting had been called to give effect to a communication he had received from the Commission on Asylums for the Insane, that the Branch should elect two or more of its members to give evidence, as representing the views of the Association, on the questions now before the Commission.

After some discussion, it was resolved that the President, Mr. J. T. Rudall, and the Honorary Secretary, Dr. Neild, be the representatives of the Branch for this purpose. It was further resolved that the following be the subjects to which the particular attention of the Commission be directed:—1. The responsibility of medical men giving certificates in lunacy. 2. The medical superintendence of lunatic asylums. 3. The desirability of there being private asylums. 4. The necessity of temporary receiving houses. 5. The expediency of better provision for the treatment of dipomania.

SOUTH AUSTRALIAN BRANCH.

MONTHLY MEETING.

Held at the Adelaide Hospital, May 28th, 1885; Dr. C. Gosse, president, in the chair.

A letter was read from the Under Secretary, acknowledging and accepting with thanks the offer of surgical assistance from the Branch, should such be necessary in the event of hostilities arising.

Exhibit:—Dr. ROBERTSON forwarded a pin which had apparently been passed by an infant, per rectum.

Dr. LENDON then read the notes of his case of depressed fracture of the skull, which will be found on page 272.

Dr. GARDNER then read his notes of a case of depressed fracture of the skull, as published on page 273.

Mr. JAY remarked that:—As Dr. Lendon has given an outline of the case of the two gentlemen who met with a rather peculiar accident on the cricket field, a short time ago, perhaps it would not be out of place to mention some points in connection with the other, who, unfortunately, never recovered from the injuries then received.

He had seen both cases almost immediately after the accident took place; the case mentioned by Dr. Lendon had recovered consciousness, but was still in a very dazed condition. Mr. S. was completely unconscious, and presented the ordinary signs of severe concussion.

The nature of the accident, viz.:—The collision of two persons' heads while running in opposite directions, was in itself peculiar, and led me naturally to give a favourable prognosis.

The external injuries amounted to nothing beyond very slight bruising over the right temple, where the jaw of Mr. F. struck him. He lingered for eight days; his symptoms during that time being very variable; constant variations of temperature and pulse; periods of restlessness and convulsive movement, alternating with coma; irregular dilatations and contractions of pupils. During one period Dr. Way (who attended him in conjunction with myself) and I both noticed a very peculiar and unaccountable dilatation of the left pupil when the head was turned on to the right side—this occurred some 3 or 4 times. We, of course, took particular care to see that this was not caused by any alteration of the amount of light, or any other extraneous circumstances.

The points worthy of notice in the case were:—The character of the accident; the fatal termination of the case from seemingly so slight a cause; the difficulty of ascertaining whether there was any fracture of the internal table; the varied symptoms of concussion, compression, laceration of the brain by contrecoup, (?) and, finally, inflammation; the peculiar dilatation of the pupil, which I have mentioned; and, finally, the question whether the remarkably rapid development of Mr. S., which took place prior to his accident, in any way predisposed towards the fatal termination of the case.

Dr. GARDNER exhibited a case of cancer of the tongue in a woman aged seventy three. Preliminary ligature of the lingual artery and removal of right half of the tongue; removal of the secondary gland fourteen months after. Recovery.

Also a case of cancer of the tongue, with enlargement of the sub-maxillary gland. Removal of the sub-maxillary gland; ligature of the lingual artery; removal of the right half of the tongue. Recovery.

Also a case of Carden's amputation for deformity of the leg after infantile paralysis. Recovery, with painful stump.

Dr. STIRLING exhibited a case of double Colles' fracture, with excellent result in both arms.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, AUGUST 15, 1885.

EDITORIALS.

CREMATION.

SINCE our last issue, a conference on sanitation has been sitting in Sydney. It was convened under the auspices of the Institute of Architects of New South Wales. Discussions on various branches of this science have taken place, and have been a means of calling public attention to much needed reforms. With others, cremation was discussed, and amongst the speakers were Drs. Anderson Stuart, Craig Dixon, and Wilkinson, who spoke in favour of it when relating to the bodies of persons dying from infectious diseases; and Dr. Belgrave, who argued in opposition to the proposal, contending that, as relating to human bodies, cremation was unnecessary and indecent. It is unquestionable that, as a means of avoiding the contamination of the soil, water, and even sometimes the air, which must occur near where a dead body is interred, cremation would be the remedy, and very great sources of danger to the health of people living in the neighbourhood of cemeteries would no longer exist. As a means of reducing the remains of deceased humanity to their original elements, it is at once the quickest, the most cleanly, and when all the circumstances are carefully thought out, and fitting appliances for the purpose provided, the most decent. The only practical objection that can be made to it is one of some force, viz., that when a body is burnt, all evidence is destroyed should suspicion be aroused as to the cause of death subsequent to cremation (and there is no doubt that in cases of poisoning valuable evidence has been worked out by the examination of bodies which, in the interests of justice, have been exhumed). This would be effectually guarded against by a fitting law, requiring an examination of every body in which the medical man in attendance was not perfectly satisfied that there were no suspicious circumstances surrounding the death. Much less facility for the destruction of life by wilful poisoning would be afforded than exists at present in New South Wales, where there is no law requiring a certificate of the cause of death

from a qualified medical practitioner, but where the registrars, with the cognizance of the Registrar General, are in the habit of accepting the certificates of men practising medicine who have not had the slightest medical education, have never dissected or studied under any teacher, the proper callings of some of them being that of groom, printer, cooper, publican (who might be supposed to know something of doctoring spirits), shoemaker (a bad one at that), and many others of similar stamp. The acceptance of certificates from such men as these is much more likely to become a means of concealment in a case of poisoning than the destruction of the body by fire.

In ancient times cremation was the almost universally used means for the disposal of the dead, especially amongst the more civilised nations. In the 18th century before Christ it was very general, and it again was revived amongst the Romans about the Christian era. Human affections have been much the same at all periods of the world's history, and it is not unreasonable to suppose that, were cremation again revived, the prejudices in favour of burial would quickly subside, and the rapid destruction by fire, instead of the slow process by decomposition, of the remains of lost loved ones, would, as in ancient times, be accepted as the most decent.

Any objections to cremation, beyond the one we have previously mentioned, are purely matters of sentiment, and there is nothing in the world which more absolutely bears out the truth of the old proverb, "out of sight out of mind," than the preference shown for burial over cremation. A body is generally placed in the ground before decomposition has progressed to any great degree, and it is only by those who have been present at the exhumation of a body, some weeks after burial, who can realise the disgusting festering mass which poor humanity becomes at that time. Were it possible for sorrowing friends to realise what the body of their lost loved one had become, under the present system, long before their loving feelings had become blunted by time, the sentimental preference they might have for burial would quickly be destroyed, and the change to cremation welcomed with enthusiasm. We think it would be very unwise to attempt any violent change, but believe that it would be well for the sanitary well-being of the community if cremation were legalised, and provision made in the neighbourhood of the larger cities of Australia for its being carried out in the instances of the bodies of those persons whose friends were sufficiently enlightened to cast aside unthinking prejudice, and, by their example, gradually educate the people to its general adoption.

Even in Spain, which is not generally credited with being the most advanced country in Europe,

the Sanitary Council has formulated the following propositions with the view of encouraging and regulating the practice of cremation in that country :—

1. Cremation should be voluntary, except during times of epidemics and after great battles.

2. That cremation may be used in the case of an individual who desires such disposition of his body by will.

3. That cremation is not authorised on the mere petition of relatives.

4. That minors may be cremated on the petition of parents.

5. That no cremation shall occur where a medical certificate of death from natural causes is not presented.

6. That no cremation is allowable in those cases in which death from unnatural causes is reported.

7. That the dead from hospitals and pauper asylums shall not be cremated.

The crematory of Siemens, a resident of Dresden (Saxony), has been proved to be the most practical and economical one invented. It can be heated to from 600 to 800 degrees centigrade in five hours, and will then reduce a human body to ashes in $2\frac{1}{2}$ hours, and this without producing the slightest smell or other sign of the destruction going on.

The cost is not great, as it can be accomplished by means of half a ton of fuel for each body.

CLINICAL INSTRUCTION AT THE MEDICAL SCHOOL OF THE MELBOURNE UNIVERSITY.

At a meeting of the Council of the Melbourne University, held on July 20, the following report was considered and adopted, with the understanding that the provisions therein recommended should only take effect from the beginning of the coming year, the chairman of the committee to be informed that the council will appoint whomsoever they recommend to discharge the duties specified in paragraph 3 of section C :—

"Melbourne, June 27, 1885.

"The Chancellor, Vice-Chancellor, and Members of Council, University of Melbourne.

"Gentlemen,—On behalf of the members of the staff of the Melbourne Hospital signing the late letter to the University Council in reference to the improved clinical instruction of medical students, we beg to acknowledge the receipt of your communication dated 22nd June, 1885 (No. 332), and in reply thereto to report as follows :

"At a meeting held for the purpose of discussing 'the mode in which our share of the hospital fees and the amount given by the University for lectures be distributed,' it was decided to forward the following suggestions for the consideration of the council :—

"(1.) To leave the whole distribution of fees as at present amongst the whole of the in-patient staff, the distribution being made at the end of the clinical year,

and the council having previously gained from existing hospital records satisfactory proof that the different members of the staff had, in accordance with hospital rules 6 and 18, attended at least twice weekly, and on each occasion given clinical instruction to the students.

"(2.) To allot the further sum of £500 from the University chest as follows :—Divide the sum of £300 amongst the four in-patient members of the staff, who have consented to give extra clinical lectures for the remainder of the year, and until final arrangements are made, pay £20 to each of the out-patient staff who undertakes the necessary work, and will give the necessary certificate for out-patient practice for the rest of the present year.

"It was further decided, that to insure the attendance of the students, and as an official guarantee for regularity in both students and staff, something more definite than existing arrangements, and more specific than existing requirements, was needed.

"(1.) It seems to the staff essential that the University Council should issue instructions, that prior to admission to the next ordinary examinations, the following certificates must be forthcoming from the students concerned :—(a) From students in the Third Year Medicine—1, Certificate of three months' out-patient surgical practice, signed by one surgeon ; 2 (as at present), Certificate of surgical in-patient practice, signed by three surgeons ; 3, Certificate of having attended two-thirds of the clinical lectures on surgery. (b) From students in the Fourth Year Medicine—1, Certificate of three months' out-patient medical practice, signed by one physician ; 2 (as at present), Certificate of three months' in-patient medical practice, signed by three physicians ; 3, certificate of having attended two-thirds of (either medical or) surgical clinical lectures. (c) From Students in the Fifth Year Medicine—1 (as at present), Certificate of in-patient medical practice, signed by three physicians ; 2, Certificate of having attended two-thirds of clinical lectures on medicine.

"(2) It seems necessary to issue to the staff the following recommendations :—(a) A time table be posted up in the students' room at the hospital, to be reasonably kept by those signing certificates, the hospital authorities being requested to forward to the council the necessary record of regularity. (b) A roll-book be kept to mark attendance at clinical lectures. (c) In all other branches of hospital practice, record of attendance to be left to the right feeling of the surgeon or physician signing the certificate. (d) The times for delivering the clinical lectures to be, for each lecture, at one of the ordinary clinical attendances during the latter half of each fortnight.

"(3.) It seems wise that the council should appoint some one with the power, for the purpose of bringing the individual student into rapport with that portion of this scheme which immediately concerns himself.

"In conclusion, we beg to state that by adopting the specific suggestions herein detailed, the council will be giving to the staff a necessary control over the students, and will gain a satisfactory guarantee that clinical instruction and clinical lectures are both regularly imparted and regularly attended. As a minor suggestion, we would beg to urge that in the interests of the students, and to increase their clinical opportunities, it be so regulated by the council that no lectures to third, fourth, and fifth year medical students be delivered away from the hospital between the hours of a quarter-past 9 a.m. and 1 p.m.

"Awaiting your necessary instructions, we have the honour to remain, gentlemen, your most obedient servants.

"J. MOLONEY, Chairman.

J. W. SPRINGTHORPE, Secretary."

THE MELBOURNE EYE AND EAR HOSPITAL, AND ITS HONORARY MEDICAL STAFF.

At an adjourned special meeting of the committee of the Victorian Eye and Ear Hospital, held on July 7th, the sole business was the consideration of charges made against the institution by two persons named W. Gunn, and Bodey. The former stated that Dr. Bowen had refused to admit his son to the Hospital, the latter that his son was not admitted to the institution until after he had been treated by Dr. Gray, as a private patient, for a month.

It appears that Mr. Gunn is a well-to-do man, and that Mr. Bodey was so well off as not to have been entitled to the gratuitous medical attendance which admission to the Hospital involved. The committee had no choice but to exonerate Drs. Bowen and Gray from all blame, and, as in duty bound, added to this resolution a special acknowledgment of the unremitting care and skill bestowed by these gentlemen, for many years past, on the patients of the charity.

The complaint says but little for the judgment and sense of decency of the persons who formed the deputation to the Victorian Premier on this matter; some of them politicians with "an axe to grind," and local votes to secure; others, simple citizens, with heads even softer than their hearts, and their bump of benevolence unduly developed, always providing that their desire to be charitable, consequent on it, can be exercised at other people's expense—in this instance at that of the medical men.

With the arrangements in force for years past, the decision as to the admission or non-admission of patients to this Hospital has been left to the decision of the honorary medical officers, who not only had to take into consideration the suitability of the case when judged from the pathological standpoint, but also its eligibility from the pecuniary position of the patient or his friends.

In these cases, when exercising a just and proper discretion, they refused to admit them as ineligible, from the monetary position of the applicants, and were at once accused of avarice in declining to treat well-to-do people except as private patients. The glaring absurdity of this charge is made apparent when it is pointed out, as was done by a just and fair article in the *Argus* of July 16th, that these gentlemen have, during the last fifteen years, attended 4,000 indoor patients, performed 7,000 operations, and that the attendance of out-door patients has amounted to over 200,000 during this period, and that, at the very lowest estimate, the money value of these services rendered is more than £100,000.

We think that, as an accusation of avarice has been made against members of our profession, we may pertinently ask in what other calling are to be found individuals who bestow in one form of charity alone, either in money or kind, upwards of £8,800 per annum each, and this not for a limited period, but for year after year.

We think that provision should be made in all hospitals by which the duty of the medical officers, in relation to the admission of patients, should solely be confined to their suitability as regards the illness from which they are suffering, and the likelihood of their receiving benefit by hospital treatment; and that all the enquiries relative to their pecuniary resources should be relegated to some lay official or officials, whose special duty it would be to protect the institution from imposition.

The malcontents in Victoria, in relation to the Eye and Ear Hospital, are doing their utmost to induce subscribers and others from sending monetary help to it, and are seemingly doing their best to bring about its closure; or perhaps their wish is to excite such disgust in the minds of the present honorary medical staff as to induce them to resign, as a protest against as gross an exhibition of ingratitude, on the part of a section of the public, as it is possible to imagine. Should they succeed in their nefarious designs they will fully realize the position of the individual who, with or without provocation, "cuts off his nose to spite his face."

NIGHT MEDICAL ATTENDANCE ON CASUAL PATIENTS.

We republish below a letter written by Dr. Roth, to the *Sydney Morning Herald*, the practical good sense of which is admirable. His suggestion is the solution of a most difficult problem, which every surgeon is frequently hard put to it to solve, when he has to decide whether he will professionally attend an unknown person unprepared to produce the necessary fee on the spot. The refusal is made with that reluctance which every man feels when called on to relieve urgent suffering; but the bitter experience we have all earned of the profuse promise and slender performance made by people under these circumstances excites that disinclination everyone feels to be made a fool of, and without something more tangible than mere words is produced it must in all prudence be made. Many people seem possessed with the idea that it is nothing for a medical practitioner to break his rest, leave his bed, undergo all the mental labour of deciding on the treatment of a serious case, and devote the professional knowledge, acquired at great expense after years of study, for

the benefit of a person he has never seen before, has not the slightest personal interest in, and who perhaps, when restored to health by the unpaid for visit, is met reeling along the street, and greets the doctor with a drunken leer of triumph at his smartness in obtaining professional aid without payment. This is no imaginary picture but a circumstance which happens daily. Should Dr. Roth's suggestion, in which there is nothing impracticable, be adopted, the profession and the public will remain under lasting obligation to him.

We now append Dr. Roth's letter to the editor of the *Sydney Morning Herald*.

SIR,—It has fallen to the lot of myself and many other medical men in Sydney to be called out at night to attend to urgent cases. Unfortunately, it generally happens that we are not remunerated for our disturbed rest and trouble, but are put off with a promise to pay at some definite or indefinite future time. It is for this reason that I, and I dare say some of my colleagues, refuse to leave the house unless paid there and then. Undoubtedly very often a case is very urgent; the caller has no fee about him, and has to ring up one doctor after another until one can be induced to visit the patient. It is to remedy this bad state of affairs that I wish to bring before your notice the working of the night medical attendance in Paris, a service which was introduced some years ago by my friend, Dr. Passant, of that city. At every police station a register is kept of the names of medical men who are willing to attend to night cases, their fee being guaranteed by the police. A poor person is taken ill late at night. A friend goes to the nearest police station, whence a police officer accompanies him to the house of one of the above-mentioned doctors, who, being rung up, and seeing a policeman, is only too glad to attend to the case, as he is certain of his fee. The fee is recovered by the police from the patient, or if he be indigent, it is paid out of the public money. I think it very desirable that the above service be introduced into Sydney and other cities and towns in Australasia.

I am, &c.,

REUTER E. ROTH.

DEATH UNDER CHLOROFORM IN THE SYDNEY HOSPITAL.

THE Jury, in an inquest held on the body of Olivia Green, who died in the Sydney Hospital on July 30, whilst under the influence of chloroform administered by one of the resident medical officers alone, for the purpose of reducing a fracture of the leg without pain, added a rider to their verdict to the effect that in future chloroform should never be administered in the Sydney Hospital except in the presence of a second medical man. This opinion, no doubt, is one that should be acted on as far as possible, for the presence of a second practitioner relieves all concerned from heavy responsibility, and in those cases which require surgical interference, enables the surgeon to do his work uninterrupted by thought as to the effect of the chloroform on his patient, at the same time allowing the admini-

strator of the anæsthetic to bestow undivided attention on this special duty. We think, however, that to make a hard and fast rule to this effect is most injudicious. Many times the duties of the resident officers are such as to render it impossible, perhaps, for some hours for two to be able to bestow their attention on the same case at the same time, and it might arise that a patient would be kept in unnecessary pain and suffering for a lengthened period by the impossibility of a second medical man being at liberty to attend when, but for this rule, a single one would have been able to administer the chloroform and do all that was required immediately. The only way in which this could be met would be by the appointment of a special officer, whose sole duty it should be to administer anæsthetics in every case requiring them, and who should have no other duties that could interfere with his special one. It would mean considerably increased expense in the conduct of the hospital, and if it is demanded by the public through the jury, the public should pay for it by increasing their subscriptions.

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SYDNEY.

SHORTLY after the death of Dr. Fortescue, there appeared in the Sydney papers the above advertisement. We at once communicated with his executors, and they have courteously informed us that not only have they given no authority in any way for such a derogatory use of the well-known name of our deceased *confrère*, but are highly indignant at its unauthorised use, and that they are using their best endeavours, by the aid of legal proceedings, to put an end to the scandal. Dr. Fortescue was not the style of practitioner to have a universal remedy, but was one who gave his best thought to every case, no two of which are ever exactly alike, and treated it accordingly. We have power to do no more than to call the attention of the profession to this base use of an illustrious name, for the pecuniary benefit of advertising druggists, and believe that medical men will express publicly the disgust which they must feel.

THE MONTH.

NEW SOUTH WALES.

A CONFERENCE to inquire into the question of sanitation, under the auspices of the Institute of Architects of New South Wales, was commenced at the Town Hall, Sydney, on July 15, under the presidency of Mr. Thomas Rowe, President of the Institute of Architects; the last sitting took place on July 29, when an adjournment was made to some future day. The conference not only dealt with the subject of sanitation generally, but also with special subjects such as "Public Instruction on Sanitary Matters," "Pneumatic and other Systems of Drainage," "Cremation," &c. Resolutions were passed by a large majority in favour of the introduction of a clause into any new Sanitary Act permitting cremation, and also that it is the bounden duty of the Minister for Public Instruction to add elementary instruction on the laws of health to the ordinary curriculum of school work. Amongst the gentlemen who expressed their views at the conference, were Drs. Belgrave, Craig Dixon, Dansey, Goode, Kendall, Quaife, and Wilkinson.

ON August 9 a case of variola was discovered on board the French mail steamer "Oceanien," in Sydney harbour, and on examination of the crew by Dr. Ashburton Thompson, two more of them were found to have been suffering for 16 days with a mild attack of small-pox. The disease existed during the time the steamer was in Melbourne.

THE Colonial Secretary has stated that a Noxious Trades Bill will be submitted to Parliament along with the Public Health Bill.

THE Commandant, Colonel Richardson, has asked Surgeon-major Williams to furnish a detailed scheme and the probable cost of establishing and maintaining an ambulance corps sufficient for the service of the whole 3,500 men who compose the New South Wales forces. The project that will most likely find favour with the authorities is that of having a small ambulance corps in Sydney, augmented by partially paid forces maintained in the different country towns.

A TENDER has been accepted for the erection of a hospital at Nyngan, at a cost of £870. Nyngan is the centre of a pastoral district, 377 miles N.W. of Sydney.

THE Committee of the Orange hospital have accepted plans for the addition of a fever ward to their present buildings, the foundation stone of which is to be laid about the beginning of November.

THE committee of the Maitland Hospital have passed the following resolution:—"That, in consequence of the urgent necessity which exists for the erection of a contagious and infectious diseases hospital in this district, the secretary be instructed to write to the Colonial Secretary, informing him that if he will promise to place £1,525 on the Estimates to cover the cost of such a building, this committee pledges itself to at once borrow the money and proceed with the erection of the building without delay."

It has been decided by the residents of Bowral, a railway township, 80 miles south of Sydney, to establish a cottage hospital for their district.

THE formal opening of the Balmain Cottage Hospital by the Premier, Sir Alexander Stuart, took place on August 1. Since the opening of the hospital for the reception of accidents on June 28, nine cases had been admitted, and one death had occurred. The hon. medi-

cal staff consists of Dr. Evans, senr., Dr. Evans, junr., and Dr. Carruthers, with Dr. Davidson as consulting surgeon.

PROBATE of the will of the late Dr. Geo. Fortescue was granted on July 16; the amount being sworn under £32,394.

DR. MURRAY ORAM has been appointed lecturer in clinical medicine, and Dr. G. T. Hankins lecturer in clinical surgery at the Sydney University, upon the usual terms as to duties and remuneration.

JOHN BERNAL, L. et L. Mid. K.Q.C.P., Irel., 1883, late of Limerick (Ireland), died on board the Orient steamer "Potosi," in Sydney harbour, of inflammation of the lungs, on August 5, at the early age of 24 years.

DR. HAROLD LYTTON CUMMINGS has commenced practice at Gunning, a small town, 165 miles S.W. of Sydney.

DR. H. FOORD-CLARK, who lately removed from Moree to Tamworth, has been appointed Medical Officer to the Friendly Societies of Tamworth, and also Honorary Surgeon to the Tamworth Hospital, in the place of the late Dr. Houghton.

DR. DOYLE GLANVILLE, late staff-surgeon of the N.S.W. contingent in the Soudan, and formerly surgeon with H.M. troops in Zululand, has been appointed medical officer on the staff of H.M. special commissioner for New Guinea, in the place of Dr. Elsner, who is unable to accompany Major-General Scratchley on his mission.

DR. E. E. GRIFFITHS, of Blayney, has the intention of visiting the old country; during his absence Dr. C. G. Thorp will carry on his practice.

DR. G. H. HAMILTON, of Petersham, has removed to St. John's-road, Forest Lodge, Sydney.

DR. N. R. KING, of Moruya, who is leaving for a trip to Europe, has been entertained at a public banquet by the residents of the district, when an address was presented to him by the members of the local Mechanics' Institute, together with a testimonial. During his absence Dr. J. T. Burgoyne, late of Emmaville and Tumberumba, will carry on his practice.

MR. WILSON RAMSAY, M.R.C.S., Eng., 1839, formerly an Assistant Surgeon in the British Army, died at Gulgong on July 15, aged 68 years. Mr. Ramsay had retired from practice some years ago.

DR. ARTHUR ROBERTS, resident medical officer at the Prince Alfred Hospital, Sydney, has resigned; Dr. Roland Danvers Brinton has been appointed his successor.

DR. SCHWARZBACH has returned to Sydney from his trip to New Zealand and Fiji, and resumed practice as an Oculist, at his former residence, 151 Macquarie-street.

DR. SCHWARZBACH, of Macquarie-street, Sydney, has asked us to inform our readers that he has received from Berlin a large quantity of cocaine hydrochlor. (the very best), and that he is willing to let medical men have some at cost price, in phials containing 10 grains, for one pound.

DR. R. WORRALL, late of Waverley, has commenced practice at College Street, Hyde Park, Sydney.

NEW ZEALAND.

IN the Legislative Council, the Hon. Colonel Brett has given notice to move—"That the correspondence in connection with the Christchurch Hospital be printed."

The *New Zealand Times*, commenting on the notice, says:—"Horrible as is the character of this blood-curdling correspondence, it is, nevertheless, painfully instructive, and reveals a state of things which—whatever may be the true version of the facts set forth—cannot, with any decency, be permitted to continue in a civilized country. It is impossible that the matter can be allowed to rest where it now stands."

DR. GRABHAM, Inspector of Asylums in New Zealand, in his last annual report, speaks very highly of the Medical Superintendents of the various asylums. Of the superintendent of the Seacliff Asylum, Dunedin, he says:—"Under many difficulties Dr. Neill is gradually bringing the asylum into excellent order. He is indefatigable in his efforts, and possessed of great administrative ability." Of the superintendent of the Wellington Asylum, he says:—"For his zeal in his work, and the numerous radical improvements which he has carried out, Dr. Levinge deserves my warmest approbation." Dr. Hacon of the Christchurch Asylum, Dr. Young of the Auckland Asylum, and Dr. Boor of the Nelson Asylum, also come in for a good deal of praise.

THE Annual Meeting of the Canterbury Medical Society was held in the Board-room of the Christchurch Hospital on June 11, 1885. The following officers were elected for 1885-1886:—*President*, Samuel A. Patrick, M.R.C.S.E., L.S.A., M.D., Vienna; *Vice-Presidents*, John Guthrie, M.D., Glas., and Charles M. Anderson, M.R.C.S., Eng., L.S.A.; *Treasurer*, Charles M. Anderson, M.R.C.S., Eng., L.S.A., Lond.; *Hon. Secretary*, Walter E. Hacon, L.R.C.P., Lond., M.R.C.S., Eng., L.S.A., Lond. A resolution was passed unanimously thanking the Hospital Board for the use of the board-room.

A VERY successful performance, by amateurs, of Douglas Jerrold's nautical drama "Black-eyed Susan" was given at the Christchurch Oddfellows' Hall, on June 30, in aid of the Sunnyside Asylum Recreation Fund.

AT the civil sessions of the Supreme Court, Auckland, on July 15, Dr. Caldwell, of Kawakawa, recovered £50 damages against George Brewer, a blacksmith, for slandering his professional ability in setting a leg of Brewer's son.

DR. J. W. COX, late Resident Medical Officer at the Sydney, St. Vincent's, and Prince Alfred Hospitals, Sydney, has commenced practice at Waikai (Switzers), in a gold-mining district, 140 miles S.W. of Dunedin.

DR. E. D. M. MACKELLAR, of Upper Queen-street, Auckland, has removed to St. Mary's Parsonage, Parnell, a suburb of Auckland.

QUEENSLAND.

DR. KESTIVEN has served a writ on the Brisbane Corporation for £3000 damages for injuries alleged to have been sustained through being thrown from his buggy in an excavation made by the Corporation in consequence of the alterations of the levels for the laying of the tramways.

DR. JOS. AHEARNE is a candidate for the new seat in Parliament for Townsville.

WILLIAM AUGUSTUS CONCANNON, L. et L. Mid. K.Q. C.P., Irel., 1868, L. et L. Mid. R.C.S., Irel., 1870, of Brisbane, and formerly of Dalby, died at his residence, Fortitude Valley, on July 30.

DR. JOHN ROBINSON BENSON, M.D., Qu. Coll., Kingston (Canada), J.P. of Brisbane, whilst on a visit at East St. Kilda, near Melbourne, died there on July 25, aged 48 years. Dr. Benson practised for many

years at Gympie, where he held the positions of Honorary Surgeon to the local hospital, and of Government Medical and Health Officer for the district. Quite recently he was appointed a member of the Queensland Pharmacy Board.

DR. G. SPELLINI, late medical officer of the Palmer River district hospital has commenced practice at Warwick, an agricultural township near the southern border, 166 miles S.W. of Brisbane.

SOUTH AUSTRALIA.

PROFESSOR LAMB, M.A., F.R.S., Professor of Chemistry in the Adelaide University, was, on July 29, the recipient of a testimonial by the professors and students of the University, on the occasion of his departure for England, where he will probably remain, though a hope was expressed that he would soon return to the colony.

DR. P. M. WOOD, of Palmerston, Northern Territory, has been appointed a member of the Local Board of Health.

TASMANIA.

THE HON. DR. H. BUTLER, Speaker of the House of Assembly, has resigned in consequence of continued ill-health. He was the first Minister of Lands and Works in 1869, when that office was created, and has been Speaker since 1877.

VICTORIA.

AT a meeting of the Senate of the University of Melbourne, held on July 21, Dr. Robertson was elected to the seat in the council, rendered vacant by the resignation of Dr. Motherwell. Attention was called to the fact of Dr. Cutts having forfeited his position as a member of the council by non-attendance at its meetings, and it was decided to take the necessary steps for the election of a member in his place. Dr. Cutts is a candidate for re-election.

RATHER an animated meeting of the Melbourne University Council was held on July 13, when it was proposed that Dr. Brownless, who is about to retire from the position of vice-chancellor, should be voted the sum of £1000 in recognition of his labours for the University. The proposal was vigorously opposed on the grounds of being illegal and inexpedient, and ultimately the matter was shelved by carrying the previous question.

SOME weeks ago Sir W. J. Clarke presented to the Trinity College the complete apparatus of a chemical laboratory, but finding that there is no apartment in the college specially adapted for such a purpose, he has generously offered a sum of £1000 for the erection of the first portion of the chemical and biographical laboratories designed in the general plan of the buildings. This liberal donation is particularly opportune, as the college authorities, in view of the steady growth of the University Medical School, have been making special exertions to assist medical students in their work by means of practical demonstrations in chemistry, histology, and kindred sciences.

DRS. FULTON, Moloney, Stirling and Webb have been appointed Clinical Lecturers to the medical students at the Melbourne Hospital.

FROM the annual report of the manager of the Alfred Hospital, Melbourne, for the year ending June 30, 1885, we learn that the number of patients under medical treatment during the twelvemonth, was—In-patients, 1,186; out-patients, 1,780; casualties, 705; total, 3,671. The number of prescriptions dispensed during the year has been 33,845, an increase of 2,943 on

last year. The daily average of in-patients again shows an increase, being 101·8, as against 97·2.

THE idea emanating from Dr. Rose, M.L.A., of establishing a Temperance hospital in East Melbourne, has been abandoned.

FROM the 1st August last, a registration fee of 1s. has to be paid monthly by every out-door patient of the Alfred Hospital, Melbourne.

MR. JOHN WILLIAM COLVILLE, of the Lands and Survey Department, has been appointed Secretary to the Central Board of Health, vice J. J. Shillinglaw, transferred.

THE annual meeting of the Victorian Medical Benevolent Association took place on Thursday, July 23, in the hall of the Medical Society. Dr. Cutts, the president, was in the chair. The report showed that the demands made upon the funds during the year had been about the same as in former years. The subscribers were congratulated upon the steady increase of the permanent fund, which was variously invested, so as to yield an average rate of interest of a little over 5 per cent. The Treasurer's sheet showed an income from all sources of £176 13s., and the permanent fund was £1,828 0s. 11d. The officers for the ensuing year were then elected, with the following result:—President, Dr. Cutts; vice-presidents, Dr. Jonasson and Mr. Rudall; treasurer, Dr. Jamieson; honorary secretaries, Drs. Neild and Graham; members of committee, Mr. Gray, Dr. McMillan, Dr. Haig, and Dr. Charles Ryan; auditors, Dr. Le Fevre and Dr. Bennie. Dr. Neild was elected a trustee in place of the late Mr. Gillbee, and the election of Mr. Fitzgerald was confirmed, the other trustee being Dr. Cutts.

AT the July meeting of the Royal Society, Dr. Henry, in the absence of Dr. Neild, the librarian of the society, proposed the following motion:—"That the Royal Society of Victoria places on record the lamented death of the late Dr. Edward Barker, and expresses its sense of the services which he has rendered to the society." He mentioned that Dr. Barker was one of the founders of the Philosophical Society of Victoria in 1857, out of which the Royal Society sprang, and that he took a very active part in the affairs of both societies. Mr. E. L. Marks seconded the motion, which was carried unanimously.

MR. FREDERICK BARTON, M.R.C.S., Eng., 1865, L.S.A., Lond., 1873, Health Officer for the city of Richmond, died at his residence, Church-street, Richmond, of acute bronchitis, on July 26, aged 44 years.

DR. CHS. B. DUIGAN, of Richmond, Melbourne, has taken Dr. George R. Moore Graham into partnership.

DR. T. M. GRIDLESTONE has resigned his position as Health Officer for the city of Melbourne.

DR. W. G. HOWITT, of Flinders-lane, Melbourne, has removed to 118 Albert-street, East Melbourne.

DR. W. H. LOW has commenced practice at Ballarat, and Dr. J. F. Malcolmson at Port Melbourne.

DR. A. B. MORRIS, late of Tauranga (N.Z.), has settled at St. Kilda, a fashionable suburb of Melbourne.

RICHARD MALCOLMSON, L. et L. Mid. R.C.P. et R.C.S., Edin., 1869, L.A.H., Dub., 1867, of Port Melbourne, died suddenly after being seized with a fit while visiting at a friend's house on Friday night, August 7. The deceased gentleman was surgeon to the naval forces of Victoria for 10 years, and only a fortnight ago he was gazetted as staff-surgeon and principal medical officer of the Victorian naval forces.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

- Elmer, Frederick William, L.K.Q.C.P., Irel., 1882; L.R.C.S., Irel., 1883; F.R.C.S., Irel., 1884.
 Lehane, Daniel, M.D., Q.U., Irel., 1880; M.D., Royal Univ., Irel., 1882.
 Martin, Morgan Thomas, L.R.C.P., Edin., 1879; L.R.C.S., Edin., 1879.
 Fitzpatrick, Alfred Edward, L.R.C.P., Edin., 1877; L.R.C.S., Edin., 1877.
 Warren, Richard Benson, L.K.Q.C.P., Irel., 1880; L.R.C.S., Irel., 1880; F.R.C.S., Irel., 1883.
 Murray, William, M.B., Univ. Dub., 1872; M.R.C.S., Eng., 1873.
 Morrow, Robert, M.B. et Ch. B., Dub., 1884.
 Gay, Herbert Moultrie, M.B. et Ch. M., Glasg., 1883.
 Kennedy, John William, L., 1870, F., 1881, R.C.S., Irel.; L.K.Q.C.P., Irel., 1876.

NEW ZEALAND.

- Cox, James Wharton, M.B. et Ch. M., Edin., 1882.

VICTORIA.

- Fullarton, James Innes, L. et L. Mid. R.C.S. et R.C.P., Edin., 1884.
 Morris, Andrew Bernard, L. et L. Mid., K.Q.C.P., Irel., 1871; L.R.C.S., Irel., 1871.
 Semple, Andrew, M.B. et Ch. M., Glasg., 1882.
 Harvey, Richard Richards, M.B. et Ch. B., Melb., 1881.

Additional Qualifications Registered:—

- Pardey, James McInery, Ch. B., Melb., 1885.
 Mollison, Crawford Henry, Ch. B., Melb., 1885.
 Kent, Charles George, Ch. B., Melb., 1885.
 Vaughan, Alfred Purdus, Ch. B., Melb., 1885.
 Maller, Melrose, Ch. B., Melb., 1885.
 Main, Harry Findlay, Ch. B., Melb., 1885.
 Florence, James William, M.D., Melb., 1885.

MEDICAL APPOINTMENTS.

- Baldwin, George Pearos, L.R.C.S. et R.C.P., Ed., to be additional Vaccinator for the district of Liverpool, N.S.W.
 Daniel, Frederick, L.F.P.S., Glasg., to be Public Vaccinator at Clifton Hill, Vic.
 Dickinson, George Dixon, M.B. et Ch. M., Edin., M.R.C.S.E., to be Health Officer for Borough of Flemington and Kensington, Vic.
 Griffith, James de Burgh, M.B. et Ch. M., Dub., to be Public Vaccinator at North Carlton, Vic.
 Haley, Frank, M.B. et Ch. B., Melb., to be Public Analyst for the shire of Rutherglen, Vic.
 Hewlett, Thomas, M.R.C.S., to be a Member of the Medical Board of Victoria.
 Kealy, Joseph Patrick, L.R.C.S. et L.K.Q.C.P., Irel., to be Govt. Medical Officer and Public Vaccinator for the District of Gulgong, N.S.W.
 Kebbell, William, L.R.C.P., Lond., M.R.C.S.E., to be a Surgeon in the Queensland Marine Defence Force.
 Malcolmson, Richard, L.R.C.P. et R.C.S., Edin., to be Staff-Surgeon and Principal Naval Medical Officer of the Victorian Defence Force.
 Newmarch, Bernard James, L.R.C.P., Lond., M.R.C.S., to be Govt. Medical Officer and Vaccinator for the district of Bowral, N.S.W.
 Pybus, John Alfred, L.R.C.P. et R.C.S., Edin., to be Govt. Medical Officer and Vaccinator for the district of Tweed River, N.S.W.

Ridgley, Thomas, M.B. & Ch. M., Edin., to be a Surgeon in the Queensland Defence Force, with the rank of Captain.

Smith, Robert, L.R.C.S., Ed., to be Public Vaccinator for Penola, S.A.

Whitton, James, M.D., L.R.C.S., Ed., to be Honorary Surgeon to the Naseby Rifle Volunteers, N.Z.

Warren, Richard Benson, L.R.C.S., Irel., L.E.Q.C.P., Irel., to be additional Vaccinator for the district of Wagga Wagga, N.S.W.

CORRESPONDENCE.

SIMULO IN THE TREATMENT OF EPILEPSY.

(To the Editor of the A.M.G.)

MY DEAR SIR,—Some months ago, whilst casually glancing through one of the many medical journals, I noticed that a new drug—South American, I believe, in origin—of the name of "Simulo," was spoken of very highly in the treatment of epilepsy.

Having under treatment at the present time a most obstinate case of epilepsy, which has resisted all ordinary treatment, I am compelled to seek something new.

Would some one or other of your readers kindly give me some account of this new drug from personal experience of its use up to the present date. All my efforts towards this end have proved futile.

The dose, the establishment at which the drug may be obtained, and any other information, will be gratefully received by,

Yours most faithfully,

G. H. S. ZICHY-WOINARSKI, M.B., &c.

Donald, Victoria, July 29.

[Dr. Larrea, of South America, was the first who recommended the treatment of epilepsy with Simulo, the fruit of *Capparis coriacea*, a plant indigenous to Peru, the medicinal properties of which have long been known to the Indians of that country. About an ounce and a half of powdered Simulo is mixed with a pint of sweet sacramental wine, and a wineglassful of the mixture is to be taken night and morning. When a lad, Dr. Larrea himself was cured with this remedy, and he states that he has used it extensively in epilepsy, hysteria, and other nervous diseases. At present this drug cannot be obtained in Australia, but Mr. T. Lakeman, of 178 Phillip Street, Sydney, will, we are sure, be happy to import the drug from America for our correspondent, if applied to.—ED. A.M.G.]

COCAINE.

(To the Editor of the A.M.G.)

SIR,—The use of this drug in ophthalmic surgery is now well established.

I can testify to its anæsthetic power, where it is necessary to use strong applications to the eye, such as for corneal ulcer, purulent ophthalmia, &c.

A few days ago I removed a pterygium without producing any pain, after using some discs of muriate of cocaine.

In May I operated upon a very nervous, fidgety lady for senile cataract. I used ten discs

of cocaine, each 1/150 gr.—the result was complete loss of sensation in the cornea. During the incision the iris got foul of the knife, for the anterior chamber was very shallow; and as it was impossible to release it, an iridectomy was performed, which caused but a slight expression of pain. The completion of the operation was painless.

The result has been very satisfactory. It has no effect in deadening pain in operations about the eyelids, when used upon the eyeball; but when hypodermically injected pain is almost entirely removed.

The field for its use is widening daily, and it is assuming a prominent place in anæsthetics where a prolonged insensibility is not required.

JAMES W. HOPE, M.R.C.P., Ed.

Medical Officer, Convict Establishment, &c.
Fremantle, Western Australia, July 10, 1885.

THE TRANSFER OF MEDICAL PRACTICES AND ITS DANGERS.

(To the Editor of the A.M.G.)

SIR,—In your publication of the 15th June I notice an article headed "The Transfer of Medical Practices and its dangers." Your article appears to point out that the agreement was not binding, because to be binding, the deed "should provide that in the event of the transferee practising in a given district, he shall pay a certain sum of money to the transferor, as liquidated damages, consequent on such practice. This sum of money is recoverable in a Court of Law as a debt, and thus and thus only can a medico pursuing a practice be duly protected."

As I drafted the deed transferring the practice, and in order to feel perfectly safe afterwards, submitted the same to counsel for opinion, and was solicitor and acted as junior counsel at the trial, I cannot but feel that your article reflects to some extent upon my professional character, and would like the real facts of the case to be known.

The sale of practice was effected by deed, which deed contained a clause that Richards should not practice, &c., under a penalty of £300 as liquidated damages. Richards threatened to become bankrupt if £300 was sued for, hence on opinion of Mr. Hesketh, of Auckland, and other counsel, it was deemed advisable to apply for injunction. This clause in the deed respecting the £300 appeared to be the only block to obtaining injunction; and upon Mr. Samuels quoting authorities to show that did not bar the right to an injunction, His Honor Judge Gillies ruled that the contention of Mr. Samuels appeared to be correct according to cases quoted, but that the system of granting injunctions in restraint of trade should not be extended; and that as it was quite discretionary with him to grant or refuse an injunction, and would leave Alexander to his remedy by suing for the £300, and would refuse the injunction. No counsel appeared for Richards.

I may add, without any disrespect to His Honor, that the legal profession, as far as I am aware, were quite in accord with me, and advised I was safe to get injunction.

I am, yours faithfully,

H. CAPLEN,
Barrister and Solicitor

Hawera, New Zealand, July 7, 1885.

REPORTED MORTALITY FOR THE MONTH OF JUNE, 1885.

Cities and Districts.	†Population.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from							
				Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Child-bearing.
N. S. WALES.											
Sydney	103,379	188	52	...	1	4	...	8	11	18	1
Suburbs	120,832	290	133	...	5	14	1	23	19	16	2
NEW ZEALAND.											
Auckland	28,401	38	18	...	...	1	...	...	...	6	...
Christchurch	16,411	18	7	...	...	...	1	...	...	2	...
Dunedin	24,931	21	6	...	...	...	...	...	...	2	...
Wellington	22,975	19	3	...	...	...	...	2	...	1	...
QUEENSLAND.											
Brisbane	26,557	44	20	} ...	...	3	...	6	2	9	1
Suburbs	9,612	31	12								
SOUTH AUSTRALIA.											
Adelaide	319,291	350	142	...	1	10	1	17	8	27	6
Adelaide	43,969	79	22	...	...	1	...	6	4	11	1
TASMANIA.											
Hobart	28,984	37	14	2	...	1	...	1	1	5	...
Launceston	18,191	22	5	...	...	...	...	...	...	2	1
Hospitals, Asylums, Gaols, &c. .	1,245	28	...	...	...	...	...	...	...	...	...
Country Districts	85,567	72	...	1	...	2	...	...	1	...	...
VICTORIA.											
Melbourne	65,791	85	} 160	...	...	14	4	15	5	67	9
Suburbs	238,618	424									

† The population of N. S. Wales, Victoria, Adelaide, and Queensland, is that of the census of 1881; New Zealand, South Australia, and Tasmania show the estimated population at the present date.

METEOROLOGICAL OBSERVATIONS FOR JUNE, 1885.

STATIONS.	THERMOMETER.				Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.		Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S. ; Long. 138° 36' E. ....	...	62.5	51.5	36.	30.078	Inches	...	...	...
Auckland—Lat. 36° 50' 1" S. ; Long. 174° 49' 2" E.	118	62.5	53.9	40.	...	2.160	12	79	...
Brisbane—Lat. 27° 28' 3" S. ; Long. 153° 16' 15" E. ....	...	81.	62.4	38.	30.206	2.34	9	72	S.W.
Christchurch—Lat. 43° 32' 16" S. ; Long. 172° 38' 59" E. ....	...	...	...	...	...	...	...	...	...
Dunedin—Lat. 45° 52' 11" S. ; Long. 170° 31' 11" E.	96.	66.	46.9	32.	...	5.76	9	74.	...
Hobart—Lat. 42° 53' 32" S. ; Long. 147° 22' 20" E. ....	...	60.	45.7	29.8	29.957	1.76	17	87	...
Launceston—Lat. 41° 30' S. ; Long. 147° 14' E. ....	...	61.9	44.4	26.5	30.044	4.76	15	83	...
Melbourne—Lat. 37° 49' 54" S. ; Long. 144° 58' 42" E. ....	...	62.1	48.1	30.2	30.048	3.629	20	...	...
Sydney—Lat. 35° 51' 41" S. ; Long. 151° 11' 49" E. ....	...	69.7	54.4	40.6	30.131	16.30	16	73	W.
Wellington—Lat. 41° 16' 25" S. ; Long. 174° 47' 25" E.	115	60.3	49.9	34.5	...	8.870	9	88	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

A CASE OF EXTRA-UTERINE FETATION, WITH INTRA-CYSTIC HÆMORRHAGE. (*Illustrated*).

READ BEFORE THE MEDICAL SECTION OF THE
ROYAL SOCIETY OF N. S. WALES.

BY THOMAS CHAMBERS, LECTURER ON MIDWIFERY AND DISEASES OF WOMEN, AT THE SYDNEY UNIVERSITY; LATE SENIOR PHYSICIAN TO THE CHELSEA HOSPITAL FOR WOMEN, LONDON, AND TO THE PRINCE ALFRED HOSPITAL, SYDNEY.

I HAVE the honor of bringing before you a case of great practical interest. It belongs to a class of cases which, fortunately, are seldom met with. It is, therefore, desirable that they should be carefully recorded when they do occur: this must be my excuse for entering so fully into detail. The majority of recorded cases are reported in such general terms, as to render them practically useless to those who are seeking for detailed information. I am one of those who believe that difficult cases should be reported, if at all, not in the abstract, but in detail, that they may be guides to the wise and careful, or beacons to the thoughtless and indifferent.

"Modest doubt is called the beacon of the wise."

This case has been seen in its different phases by other medical men. I have, therefore, asked these gentlemen to report the several circumstances which came within their cognizance, without reference to the observations of others. Thus Dr. Pickburn reports the early history; I take up the case as it presented itself to me; Dr. Knaggs made and reports the *post-mortem*; Dr. Wilkinson, Lecturer on Pathology at the Sydney University, examined and reports upon the pathological specimen; and Dr. Roth made the drawing. These several contributions have been made separately and apart, in order that all preconceived ideas might be eliminated. I have great pleasure in acknowledging my obligations to these gentlemen for their valuable counsel and assistance.

REPORT OF DR. PICKBURN.

Mrs. D—, æt. 38, came under my care at St. Vincent's Hospital some time in the month of November, 1884. She was a private patient there, but she had had a good deal of medical treatment before her admission. She said that she had been suffering from uterine troubles ever since her last confinement, two years ago, when

she had a very severe time, and had been confined to her bed for many weeks after. Since then she had always had more or less hypogastric and sacral pain, with a considerable quantity of leucorrhœal discharge. Her periods, too, had been very profuse, and for the last 7 or 8 months she had scarcely ever been free from more or less bleeding, which had caused her to become weak and anæmic; otherwise her health was good, and she was plump and jolly.

On examination, Mrs. D— was found to have a large and tender uterus, $1\frac{1}{2} \times 2$ inches over the normal; os was considerably lacerated, and the whole lining membrane was in a condition of granular inflammation; the perineum had been torn, including a greater part of the sphincture, so that she had very imperfect control.

Mrs. D— remained in the hospital about 10 days, and during that time she was kept in bed—took ergot with strychnia—and every other day the uterus was wiped out with carbolic acid. She left the hospital in much the same condition as when she entered it.

On the 21st of November I visited Mrs. D— at her own residence, and for several days continued the treatment which had been commenced in the hospital. As no improvement followed, and the bleeding still persisted, early in December I asked Dr. Chambers to see Mrs. D— in consultation. It was then decided that the lacerated cervix should be repaired, and this was done by Dr. Chambers on the 18th of December. She made an excellent recovery from this operation. And on the 26th December, the perineum was also brought together.

I saw Mrs. D., with Dr. Pickburn, on the 1st of December, 1884. The uterus was large and flabby, and the discharge was almost continuous, notwithstanding her long continued rest, combined with local and constitutional treatment. On examination, the perineum was found to be ruptured into the bowel. The parts had been partly repaired by cicatrization, but she had no power to retain soft or fluid fœces. The cervix uteri had been severely lacerated into the vaginal inlet on both sides, and, as far as could be judged, the vaginal portion of the cervix had been torn away. At any rate, it was not present, and from the cicatritial bands that were present, the fair inference was, that this accident had happened when the injury to the soft parts occurred at her last confinement. On December 18th, Dr. Knaggs administered an anæsthetic, and, assisted by Drs. Pickburn and Roth, I repaired the injury about the vaginal arch and cervix uteri. This was rather a difficult oper-

ation, and could only be accomplished by denuding and bringing together the vaginal mucous membranes situated before and behind the cervix, and leaving an opening for the os in the centre, which was kept patent by a tent of oiled silk. The repair was rapid and complete; the cone was a little puckered, a condition to be expected under the circumstances; and the new os was a little retracted. From this time the hæmorrhage ceased, and the uterus gradually assumed, to a great extent, its natural size and outline, though it remained a little larger than normal. On the 9th day after the operation, menstruation came on naturally, and continued in moderate quantity for 4 days.

On December 26, Dr. Knaggs again administered an anæsthetic, and, with the assistance of Drs. Pickburn and Roth, I repaired the perineum. This operation was a little tedious in consequence of the great injury to, and destruction of, the soft parts. Severe, and almost incessant vomiting continued until the morning of the third day, when the wound became much inflamed and swollen, and, as all repair had ceased, and the wound had opened, the sutures were at once removed, and the patient kept on one or other side; with the relief of tension the vomiting ceased, and the wound assumed a healthy, granulating surface, and healed by granulation. The result was a perfect perineum with complete sphincture control. She menstruated in the latter part of January, and again in February, naturally. In March there was just a show, a few drops only, and from this time there was no further menstrual effort. On the 9th of May she called on me and complained of constant discomfort of a stretching character about the lower part of the abdomen. She had not menstruated since February, and ever since the periods had ceased she had been subject to this discomfort, and as she had none of the usual signs which had marked her former pregnancies, she felt sure she could not be pregnant. She attributed the cessation of the periods to cold, and the pelvic discomfort to obstructed menstruation. She had neither nausea nor vomiting, neither were the breasts in any way changed. The uterus, or some similar body, was distinctly felt in the median line, reaching to about two inches above the pubis, having a transverse diameter of about two inches. A most careful auscultatory examination failed to detect any indication of placental bruit, which by this time ought to have been recognizable under ordinary circumstances. Assuming the case to be one of pregnancy, this negative sign might be explained by supposing that the placenta was attached to the posterior uterine wall, and as gestation, if it existed, could not be much more

than eight or nine weeks advanced, the feeble circulation and the possible posterior attachment of the placenta, were accepted as an explanation of the absence of the placental bruit. Vaginal examination showed that the uterus was much higher in the pelvis than is usual in the unimpregnated state, and the body was distinctly enlarged. Bi-manual manipulation clearly showed that the abdominal enlargement was due to an enlarged and rising uterus. There was nothing remarkable about the vagina or uterus beyond the fact that the former was more sensitive, and the latter a little more fixed than is usual, but these conditions appeared to be sufficiently explained by recent events, and to the possible stretching of the new cicatrices. On carefully considering the whole facts of the case, I could find no explanation for the symptoms complained of other than pregnancy, notwithstanding so many negative signs. The patient thought I was making a great blunder. However, I prescribed an occasional sedative and asked her to call again in a few weeks, which she did on June 3rd. Her condition, was in all essential respects, the same as on May 9th, only her suffering and discomfort had increased, and the uterus had advanced to midway between the umbilicus and pubis. The size of the uterus was excessive for the supposed period of pregnancy. This, together with the total absence of any auscultatory sign, suggested cystic degeneration of the ovum; there was no vaginal discharge. The vaginal indications were much the same, with this exception, that there was a greater weight and fixity about the posterior wall than had been noticed on the previous examination. There was nothing noticeable about Douglas's pouch, beyond excessive sensibility of its anterior wall. The patient had become much thinner since her last visit and could not sleep without a sedative. Although the case was very obscure, yet I felt sure that pregnancy existed, either of a normal or an abnormal character.

Late in the afternoon of June 10th, her husband called and asked me to see his wife as soon as possible, as she had been taken suddenly "very ill indeed." I went at once, and found her lying curled up on her left side, her knees drawn closely up to the abdomen, with her head over the side of the bed and vomiting into a chamber placed on the floor. Her whole surface was icy cold and appeared to be shrunken; her face was pale, pinched and anxious. She complained of agonising pain along the transverse colon, especially at its terminal extremity, so much so that she could not bear it to be touched. She also complained of forcing pains in the vagina and rectum, with a painful sense of stretching.

There was neither pain nor fulness in either iliac region. Tubal foetation and rupture of the cyst at once suggested themselves, but, on examining the vagina, I found the uterus and its surroundings much in the same condition as on the former examination, with this addition, viz: extreme distension of the rectum, with hard lumps of dried fæces. This appeared sufficient to account for the bearing down, and when to this was added the fact that all the suffering was referred to the transverse colon, and more especially to a limited space at its terminal end, the pain appeared to be due to an intestinal, rather than to an uterine cause. Was it intussusception? The treatment consisted in stimulation, hot fomentations, hypodermic injections of morphia, turpentine injections, hot bottles to the extremities, etc. When the bowels had been fairly relieved by repeated injections, the bearing-down and painful stretching passed off, but the severe pain about the colon still continued. The pulse was fairly full at 90; temperature 99; respirations 26; urine clear, but high-coloured, acid, but no albumen. In a few days the more urgent symptoms passed away, but the fixed pain still remained, though much less severe, and the vomiting remained more or less troublesome; the vomited matters appeared to consist chiefly of mucous mixed with the iced water, taken to quench her pressing thirst—not the green pea soup or porter-coloured fluids which mark extreme exhaustion. On the 16th she went for a short drive with her husband, but was a good deal tired. On the 17th she had a second attack, which resembled the first in its main characteristics, the pain on this occasion being confined to the colon, from which it radiated over the abdomen, like peritonitis; the parts were as painful to the touch as if acute peritonitis was present, but the temperature and pulse both kept below 100, so that the extreme sensibility was regarded as reflex. This second attack was followed in a day or two by jaundice, with a dull pain over the hepatic region, and troublesome vomiting, but there were no signs of impaction. The treatment consisted of small doses of blue pill and sulphate of magnesia, with mineral acid. In about a week, bile was again blended with the fæces, but during this week the patient had fallen off considerably both in flesh and strength. As the jaundice subsided, a third attack was experienced, and Dr. Pickburn saw her in my absence, and next day with me. The chief pain was always centred in the colon, and radiated over the whole abdomen. The uterine region being painful when touched, but otherwise not very troublesome. From this time, however, the colonic pains gradually subsided, and the uterine region became more sen-

sitive and painful, and the patient began to lose ground somewhat rapidly. From day to day I became more and more convinced that our real difficulty was here, and that if it could not be removed the patient would certainly die.

On July 3rd Dr. Pickburn saw her again, and we came to the conclusion that some attempt should be made to relieve her, and that the first step should be dilatation of the cervix to ascertain what the uterus contained, as I felt sure the real cause of trouble was due to some form of abnormal conception. The patient, at her own request, and with Dr. Pickburn's sanction, was removed to my private hospital, as she believed she would be better cared for there than she could be at home.

On July 7th she was admitted, and on the morning of the 8th I attempted the introduction of a tangle tent, and was a good deal surprised to find I could only put in a very fine one, not thicker than a knitting needle, and this was accomplished with great difficulty and some pain. On the 9th Dr. Knaggs gave her an anæsthetic, and with Dr. Pickburn's assistance I succeeded in introducing a fine curved tent $4\frac{1}{2}$ inches long. The difficulty of introduction was occasioned by the great projection forward of the posterior uterine wall. This tent set up some irritation, and it was deemed desirable to wait a day or two.

On the 13th Dr. Knaggs again gave an anæsthetic, and I was able to put in two long and two short, small tents.

On the 14th I could pass the finger during anæsthesia well into the cavity, and was a little disappointed to find it quite empty; but the posterior uterine wall was pressed closely forwards, so as to leave only a very narrow, compressed concavo-convex cavity. To the examining finger the anterior uterine wall was normal, the organ was centrally placed, but its fundus was verted forwards. The posterior wall was bulging into the cavity, having a cone shaped projecting prominence. As far as the finger could reach it felt uniformly dense and unyielding, without the slightest sense of fluctuation. Through the rectum was felt a similar projection having similar physical characteristics. These were carefully examined by Drs. Pickburn and Knaggs, the patient being under anæsthetic influence. It now appeared pretty certain that the case was one of extra-uterine foetation. But to which variety did it belong? From the central and elevated position of the uterus, and the very marked bulging of its posterior wall, I believed it belonged to that rare variety known to us as *Interstitial* or *utero-tubal*, or what was known to the old writers as the *graviditas in substantia uteri*, where the ovum is arrested in that portion of the tube which travels the uterine wall. In such a con-

tingency, the development of the ovum may be partly within the uterus, and partly within the tube, hence the name utero-tubal, or in the uterine parenchyma, projecting into the cavity, and invested, perhaps, with a thin layer of uterine muscular fibres, and the uterine mucous membrane.

Here I may remark that, with each removal of the tents, a small quantity of, what appeared to be clear, well-formed, and healthy pus, oozed, or appeared to ooze, from the posterior aspect of the cervical canal—not more than a few drops. This raised the question as to whether the bulging referred to was not, after all, an interstitial abscess. However, to test this point, an aspirator needle was passed through the most prominent part of the uterine wall. This drew off about 9 ounces of clear, limpid, light straw-coloured fluid, free from blood, mucous, sediment, and smell, or odour of any kind. Drs. Knaggs and Pickburn examined it—the result was as follows: specific gravity, 1000·8 of alkaline reaction, containing minute quantities of albumen, and chloride of sodium. Microscopically, nothing was found but a few oil globules, and epithelial cells. There could now be no remaining doubt; the fluid could be none other, under the circumstances, than liquor amnii, and, as a consequence, there must be an extra-uterine cyst. It was now determined to wait events, and be guided by circumstances. As the amniotic fluid appeared to be normal, it was reasonable to assume that, up to the present, the foetus was healthy. It was also reasonable to suppose that it would now die, and might, perhaps, become encysted, and remain quiescent for an indefinite period. This sequela was much to be desired.

15th. Has rested fairly well with the help of opium; the sickness is less, and the sense of tension and stretching is greatly relieved; takes nourishment better, and feels comparatively free from pain.

16th. To-day she feels much better and lighter; no sickness; takes food well, and thinks herself fairly on the way to recovery. Can sleep without opium; urine more free; bowels relieved without discomfort; skin, soft and moist. Temperature, 99; pulse, 90; respirations, easy and normal.

17th. Not so well; has not slept well, and when she did, she awoke tired and unrefreshed, with a sense of extreme weariness, such as she never before experienced. Although she had little or no pain, yet she was restless, and could not find a comfortable position for many minutes together. Pulse, temperature, and respiration much the same as yesterday.

Beef-tea, brandy and opium enemata were given every four or five hours. Ammonia and cinchona with chloroform water were given at intervals, when they could be taken. At 6 o'clock the

sickness returned, and her constant complaint was, that she was "so extremely tired and weary." She thought these sensations prevented her from sleeping. The pulse had risen to 110; the mouth temperature was 98; and the vaginal temperature 101. The features were pinched, the eye-balls sunken, the tongue dry and glazed, but without thirst. It now seemed that the time had come when we should finally determine whether anything more should be done, if so, what? I arranged for Drs. Pickburn and Knaggs to meet me at 9 p.m., and sent for her husband to meet us at that time.

9 p.m.—In all essential respects, she remains the same, still there is the same mournful complaint of her weariness. There could be no doubt but that she was failing; we were, therefore, of opinion that some attempt should be made to relieve her. The nature of the case was fully explained to the husband, and he gave his consent for us to do whatever we deemed to be best for his wife. He was told that if she was left alone, she would undoubtedly die within a limited period, also, that she might die during, or immediately after, any operative procedure, but that she might, perchance, recover. As the morphia injections which had in the past given her so much comfort, now induced vomiting, even in very small doses, Dr. Knaggs suggested that I should inject a quarter of a grain of *cocaine*. We arranged to make some attempt to relieve her at 9 o'clock on the following morning.

18th, 8.30 a.m.—She has passed a good night, slept well, and feels less wearied; no sickness during the night, and can take light nourishment. As she appeared so much more comfortable, I thought that if she had another injection of *cocaine*, and a beef-tea and brandy enema, she might get a few more hours sleep, and that she would be better able to bear the operation. This was done, and the operation deferred until 2.30 in the afternoon.

2.30.—The *cocaine* failed to procure sleep, but the enema was retained. She was low and somewhat depressed. The pulse was quick (116), but of fair volume. Now that the time had come for operation, what should it be, vaginal or abdominal?

Although the vaginal operation offered advantages, they were counterbalanced by disadvantages; abdominal section, was, therefore, elected, the idea being to secure the sides of the cyst, or uterus, to the incised wound in the abdominal parietes, to remove the foetus, to leave the placenta, and to secure a sufficient opening through which the placenta and its associated discharges might escape, without invading the peritoneal cavity. Such were the theoretical outlines mentally laid down for operative guidance. But, alas! how soon were they destined to be scattered,

as mental chaff before the biting wind of dire experience. The uterus was easily reached. It was situated exactly in the median line, free from adhesions both in front and at the sides. The omentum was adherent to the fundus, and the body was firmly fixed to the upper third of the sacrum. While the index finger was carefully reconnoitring, there was a sudden outburst from a point lying to the left, and in immediate proximity to the body of the uterus, of an immense quantity of jet-black, dirty-looking fluid, emitting an atrocious smell. In colour, consistence, and smell, it resembled sewage of the worst type. At the same moment, the sides of the pelvis, which had hitherto been quite free, became filled to overflowing with fluid of the same kind, so that it was certain there was another opening besides the one under observation. It was now clear that the whole mass must be removed, or we must at once stop. There appeared to be no alternative course. It was quite certain that, under any circumstances, the patient could not live long. If the mass was removed, she would, almost to a certainty, die on the table; while, if we stopped now, she might rally for a few hours and say good-bye to her family. However humiliating it may be to have to discontinue an operation before it is well begun, it is better to do so than to go on with a moral certainty that the patient will die on the table. The cavity from which issued the sewage-like fluid, was filled with strips of antiseptic lint and two small antiseptic sponges as a tentative measure, the abdominal incision closed by three sutures, and the patient returned to bed. She rallied wonderfully for a time, and died quietly eight hours after the operation.

DR. KNAGGS' REPORT OF THE POST-MORTEM EXAMINATION.

Patient died at 10.40 p.m.

Post-mortem examination at 9.30 a.m. next morning, in presence of Drs. Chambers and Pickburn.

Abdominal incision about $4\frac{1}{2}$ inches in median line, extending downwards from half an inch above umbilicus towards pubis, secured by three stitches.

Upon removing the stitches the anterior part of fundus of the elongated uterus presented—posterior and to the left of which was a rugged opening into a cavity, which was occupied by two sponges and some lint. These were saturated with a black foetid-smelling fluid. Upon removing the contents, the cavity was found to be a cyst, occupying a space at the back of the uterus, containing partly-organised blood clots, bathed in this black ill-smelling fluid. The quantity of this fluid, taking into consideration what saturated

the sponges, &c., and what escaped into the pelvic cavity, must have been a quart at least.

It was found impossible to isolate the uterus and its appendages—with this attached cyst—from the omentum, mesentery, and meso-colon, in consequence of adhesions, the latter structures being closely agglutinated to the posterior and upper wall of the cyst. It was with much care and difficulty that these adhesions were separated, so as to reach Douglas's pouch, which being done, the elongated uterus and attached cyst were thrown forwards, and then was discovered below the adhesion to the meso-colon a small rugged opening, through which protruded a loop of twisted foetal umbilical cord, to which, upon examination, a foetus was found attached. A quantity of the black foetid fluid was now removed from the pouch and iliac fossæ; the Fallopian tubes and ovaries, which were intact, of each side were carefully isolated from adhesions, and then the uterus replaced *in situ*. The hand was now passed down into the vesico-uterine pouch, and by means of a long curved scissors, the wall of the vagina was cut through; then the rectum and all the structures were carefully peeled off from the sacrum, from below upwards, until Douglas's pouch was reached, then the round and lateral ligaments cut through: thus the uterus, its appendages, and attached cyst, were removed *en masse*. During this procedure the foetus escaped from its nidus, and was subsequently discovered in the sacral cavity.

After removal from the body, the double nature of the cyst was discovered.

There were no signs of peritonitis.

REPORT BY W. CAMAC-WILKINSON, M.D.,
LOND., M.R.C.P.

THE parts removed from the body for examination are the uterus and its appendages, the cyst and its contents, part of the rectum, and the loose tissue in the immediate neighbourhood of these parts, in which is to be found on each side a section of each ureter.

The uterus is generally enlarged; it measures $5\frac{1}{2}$ inches from the summit of the fundus to the outer mouth of the cervix, the length of the uterine cavity being just $3\frac{1}{4}$ inches. Its greatest diameter from side to side is four inches, and its greatest antero-posterior diameter one inch and a half. The uterine wall, at its thickest part, measures $\frac{3}{8}$ inch. The junction of cervix with body of uterus is well defined, and the length of cervix is $2\frac{1}{4}$ inches.

The uterus is simply enlarged. It is not misshapen, nor does it show any evidence of inflammation. The cervical canal is patent.

Opening the uterine cavity by a mesial incision along anterior wall of cervix and body of uterus,

one finds no unhealthy condition of cervix, but in the cavity of the uterus an exceedingly soft, delicate, semi-gelatinous membrane adhering to the uterine wall in the neighbourhood of the fundus. This membrane is covered with mucous material, and is itself firmly fixed to the uterine mucous membrane.

The cyst lies immediately behind the uterus, the posterior surface of the body and neck of the uterus forming anterior wall of cyst. It fills the space between the uterus and the rectum, and on each side reaches beyond the ovaries. In general shape the cyst is pyriform, with the broad end upwards, rough measurements making its depth about 6 (six) inches, and its transverse diameter between 4 inches and $4\frac{1}{2}$ inches.

The wall of the cyst is everywhere distinct. In front it is closely adherent to the posterior surface of the uterus and also to the Fallopian tubes, and to the ovaries with their ligaments. On the right side, the membrane can be easily separated from the ovary, and then the ovary and the corresponding Fallopian tube are seen to be intact. On the left side the membranous wall of the cyst extends much further than on the right side, and the attachment to the Fallopian tube and ovary is closer. The Fallopian tube and ovary are intact. The wall of the cyst is closely adherent in its lower part with the peritoneum, forming the recto-vaginal pouch. Here a pocket is formed large enough to hold a fair-sized orange. This pocket reaches $1\frac{1}{2}$ inch below the lip of the elongated cervix. The extreme left of the cyst wall reaches quite $2\frac{1}{2}$ inches to the left of the left edge of the uterus. Possibly this distance was less when the parts were in situ. Everywhere below the cyst wall is adherent to the soft tissues in the neighbourhood, and in these tissues the ureters are found, the left ureter lying well under the cyst.

The wall varies in thickness in different parts, below it is tolerably thick, above it is thin, and it is thinnest of all in its upper and posterior part, where it is actually perforated in two places. These perforations are about an inch long and of no breadth—they are, in fact, slits in the wall. The edges of the perforations are irregular, necrosed, and stained with blood. The internal surface of the wall is smooth and clean, except at its uppermost part, where there is bloody discolouration, produced evidently by the proximity of the fleshy mass, soon to be described, and below, where blood appears to have collected by gravitation.

INTERIOR OF CYST.

Occupying the left and posterior part of the cystic cavity is a mass of tissue, which is lined anteriorly by a continuation of the membrane of the cyst wall; it is attached to the wall of the

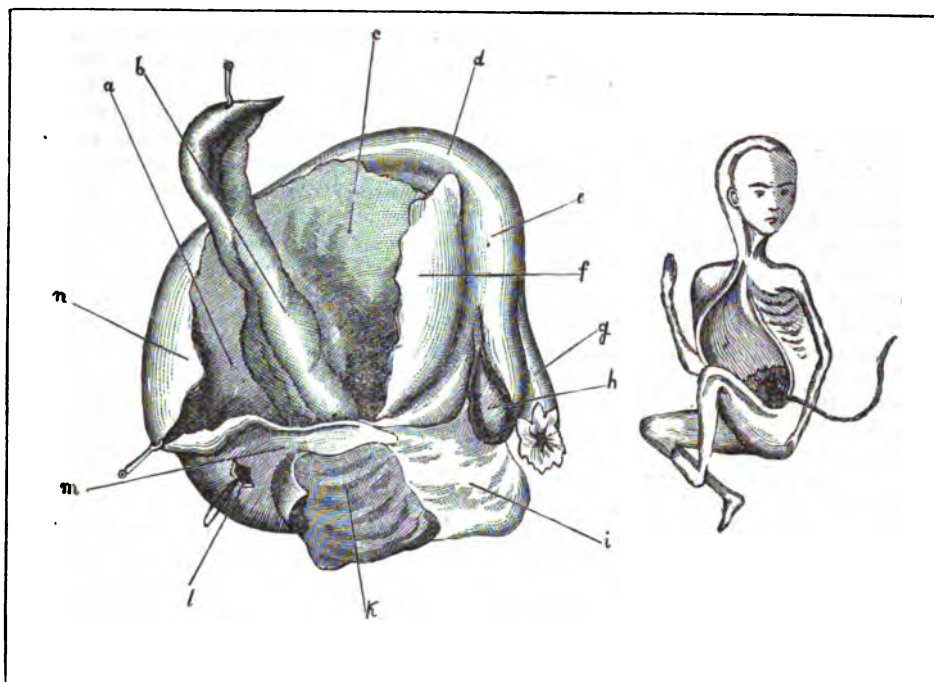
cyst by a stout mass of tissue, which has no connection with body of uterus, has a slight attachment below to the posterior surface of the cervix uteri, midway between the os internum and os externum, and thence reaches upwards, and to the left for about four inches. This mass is about as large as a closed fist, so that it occupies only part of cyst cavity.

On opening out this mass, a red, shaggy, friable and broken surface comes into view—a surface like the detached surface of a placenta. Bands of delicate membranous tissue stretch across this surface, which are free in the centre, but attached at both ends, one of these carrying the placental end of the umbilical cord. These bands are in places moderately broad. Around and intimately connected with this fleshy mass, are large ante mortem blood clots. This fleshy mass further occupies a distinct cavity of its own, which once held the foetus, to be described presently. This cavity contains clots, and its wall is deeply stained with the blood which saturates it.

The cavity containing the mass is quite distinct from the cavity of the main cyst lying in front of the fleshy mass. This cavity of the main cyst lies between the fleshy mass and the posterior wall of the uterus, and is co-extensive with the lateral limits of the main cyst, reaching, therefore, beyond the ovaries on each side. It is lined, as already said, with a smooth delicate membrane, which, apart from some blood discolouration, above and below, is clean and free from clots.

It is in the posterior wall of the cavity containing the fleshy mass that the perforations described are found; within this cavity a foetus was found.

The foetus is of a dull red colour, its right arm is flexed, its left straight down by its side; lower limbs flexed at the hip, left ankle flexed, right extended and inverted. The ribs are clearly marked out, the anterior extremities projecting, since the parts between them are sunken; the skin is here and there abraded, especially at left shoulder and left axilla. Mouth is open and tolerably large, the tongue protruding, the nasal apertures evident; pupillary membrane also seen; bones of head flattened together. The nails are well formed and the sex distinct: The umbilical cord is $\frac{3}{4}$ inch from pubes; anus formed; ears visible. There is no hair or down. Organs not examined. The foetus is much flattened by pressure; its length is six inches, and its weight two ounces; length from shoulder to elbow 1 inch; elbow to wrist, $\frac{3}{4}$; wrist to tip of middle finger, $\frac{3}{4}$; hip to knee, $1\frac{1}{4}$; knee to heel, 1; heel to tip of big toe, $\frac{3}{4}$; middle finger, $\frac{3}{8}$; attached umbilicus, $6\frac{1}{2}$ inches.



DRAWN FROM NATURE, BY R. E. ROTH, M.B.C.S.E., OF SYDNEY.

a, Posterior cyst, which contained foetus and effused blood. *b*, Septum separating cysts. *c*, Anterior cyst, containing amniotic fluid. *d*, Fundus uteri. *e*, Uterine peritoneum. *f*, Wall of anterior cyst, covered with peritoneum and reflected. *g*, Fallopian tube. *h*, Right ovary. *i*, Fat and muscles. *k*, Rectum. *l*, Opening through which umbilicus and cord presented. *m*, Cyst wall. *n*, Peritoneum covering wall of cyst reflected.

Remarks: A careful survey of this important and interesting case will, I think, lead us to attach considerable importance to the events which happened on the afternoon of June the 10th. When I first saw the patient, my impressions were that the case was, probably, one of extra uterine foetation, and that the sudden accession of the acute pain and collapse were due to rupture of the cyst: bearing in mind the obscurity which surrounded the probable pregnancy, and the period—about the 18th week—at which these symptoms appeared, although it was difficult to reconcile this view with the actual facts as they presented themselves. There certainly was a severe sense of fulness and bearing down about the rectum, but these appeared to be fully explained by the great distension to which that cavity was subjected by the presence of so large a quantity of hardened faeces. Moreover, these pelvic discomforts disappeared soon

after the bowels had been well cleared out by turpentine enema. Then there was the total absence of pain or fulness in either iliac region, neither could there be found any fulness or bulging in Douglas's pouch. Associated with these negatives, there was the positive and all absorbing suffering of acute pain along the course of the transverse colon, culminating in simple agony at the terminal extremity of that tube. Now, remembering the extreme distension of the rectum, and assuming that as an index of the distended condition of the colon generally, it appeared reasonable to reject, for the present at least, the ruptured cyst theory, and to assume that the exciting cause of the collapse was, most probably, intestinal; whether this cause was in the form of obstruction of intussusception or of colic, it was impossible to say. Either of these conditions, when acutely sudden, are accompanied by more or less collapse at their first appearance. Subsequent events, however, leave but little room for doubt as to what actually happened in the afternoon of June 10th.

I am now strongly inclined to the opinion that the actual cause of the collapse was hæmorrhage into the ovum cyst, with the probable death

of the foetus; but whether the hæmorrhage was the result of placental separation, or of undue pressure induced by over distension of the rectum, it is impossible to say. I may, however, say that the patient had spent the greater part of the day reclining on the bed, and that she had not been exposed to any of those exciting causes which are supposed to play an important part in the production of hæmorrhage, or rupture of the cyst in extra-uterine foetation—such as a blow, a fall, excitement in sexual intercourse and the like. The hæmorrhage might have been spontaneous. It is, however, a question whether the acute pain referred to the transverse colon was not, from the first, reflex and sympathetic, and whether the fecal accumulation was anything more than a mere coincidence.

Dr. Knaggs' report of the *post-mortem* shows that the uterus was unusually large; that the vesico-uterine pouch and iliac fossæ were free from complication; that both Fallopian tubes and ovaries were intact, and this is confirmed by Dr. Wilkinson's report, although they were attached to the cyst by adhesions; that both broad ligaments, in front and laterally, were also uncomplicated; that there were two cysts or cavities, one immediately behind the uterus, by which its anterior wall was formed, and its posterior wall by a membranous septum—this cavity was of considerable size, and quite empty. Dr. Wilkinson describes this cavity as a "pocket large enough to hold an orange, and reaching 1½ inches below the lip of the enlarged cervix." Nothing of this kind was felt per vaginam. High up in the rectum, above the cervix uteri, a large, unyielding body was felt, similar to that felt through the posterior uterine wall, and was supposed to be connected with it, and the question arose as to whether the aspirator needle should be passed through the rectum or through the uterine wall; the rectum fulness disappeared after the aspiration. This was, undoubtedly, the cavity from which the fluid was drawn by the aspirator on the 14th.

The second cyst or cavity was immediately behind the one just named, and bound in front by its posterior wall, behind and laterally by the chorionic membrane; in some parts it was firm and condensed, in other parts it was exceedingly thin and friable. This second cavity was considerably larger than the first, it contained the foetus, a large mass of partly organized blood clot, the placenta, &c. The sewage-like fluid had also been contained in this cyst. Its posterior wall was very closely attached to the upper third of the sacrum, and inseparably to the rectum. Now the question may arise, how are we to account for the contents of this cyst? It can only be accounted for inferentially. The fair inference is, I think, that each of the

three attacks of shock and collapse already mentioned, were occasioned by three several attacks of hæmorrhage into the cyst. The first being moderate in quantity, and coming into contact with what may be assumed to have been present, viz:—A healthy cyst surface, an attempt was made at organization and repair; and as the foetus was in all probability destroyed on that occasion, there appears reasonable grounds for believing that if no further hæmorrhage had happened, complete organization might have taken place, and the cyst might thus have become obliterated, and, perhaps, have remained for years without further troubling the patient. But instead of this favourable termination, there came a second hæmorrhage with the second collapse, and as, perhaps, there was little or no healthy cyst surface remaining unoccupied, the effused blood simply coagulated, this view is supported by the fact that several offensive coagula escaped when the cyst first burst, such as often escape when a suppurating hæmatocoele gives way. If this much is admitted, we may assume that the third attack of collapse was marked by a third hæmorrhage, and that this third effusion remained in a fluid state, and from some unknown cause decomposition took place, hence the production of the black "ill-smelling fluid" mentioned by Dr. Knaggs. Having offered this crude and theoretical explanation of the contents of the cyst, I should like to venture some explanation of the severely marked pains along the transverse colon, which characterised this case. Although it is equally crude and theoretical as the explanation of the cyst contents. You will remember that Dr. Knaggs found "the mesentery and meso-colon closely agglutinated to the cyst, at its posterior and upper aspects. The mesentery was very much thickened and condensed." That portion of the mesentery which is attached to the transverse colon, derives its nerve supply from the superior mesenteric plexus—these nerves are denominated the *middle colic nerves*. The descending colon being supplied by the *left colic nerves*, furnished from the inferior mesenteric plexus. Thus we may suppose that as the cyst became filled with the effused blood, it would exercise pressure, and induce tension on the attached and indurated mesentery, exciting irritation of the terminal filaments of the nerves, distributed to the transverse colon. This appears to me to account for the great pain in the transverse colon, as well as offering a reason why it should terminate so abruptly at the terminal end of that tube. If this theory is correct, we must conclude that those distressing pains were purely reflex and sympathetic, and that the severe pains radiating from the transverse colon over the whole upper surface of the abdomen, which so closely simulated the

pains characterizing peritonitis, were due to the same cause—irritation of the branches of the superior mesenteric plexus. Now, another question presents itself, was this an example of tubal or of abdominal pregnancy? From the facts observed at the *post-mortem*, and confirmed by Dr. Wilkinson, viz.: that the Fallopian tubes, ovaries, and broad ligaments, were found intact, save by juxtaposition, and that the ovum was attached to the sacrum, not involving either broad ligament, I think there cannot be a doubt about this being an instance of abdominal pregnancy, pure and simple; although there are not wanting writers, both "ancient and modern," who deny the existence of abdominal pregnancy as a primary complication.

Another curious and interesting question presents itself, which the *post-mortem* facts suggest, viz.:—How did it happen that there were two cysts, each containing fluid, so widely different in their physical characters, as to leave no doubt about the fact? I freely acknowledge the difficulty of this question. It is, however, possible that the two cysts may have co-existed from the beginning, one containing the foetus, placenta, and a portion of liquor amnii, enclosed in the amnion, while the other was representative of the space between the true and false amnion which exists during the early days of pregnancy, and containing a fluid closely analogous to the liquor amnii. (not the magma réticulé of Velpeau). If this is so, the membranous septum before referred to was the amnion. I may say that instances are on record where the foetus has been found in the tube, while the placenta was in the uterus. Hay published such a case at the beginning of this century.

As touching the foetus, there are reasonable grounds for believing that it had reached the end of the 18th week of its development. The mother last menstruated during the last week in February. Allowing the usual week's grace, she would reach the 9th day of March, and her first collapse occurred on the 10th day of June—three calendar months. Referring to the representative British, American and Continental obstetric writers, I find their opinions differ considerably as to the precise material development of the foetus at this period (third month). One says "its weight is from 70 to 800 grains"—an expansive margin—and "its length from $2\frac{1}{2}$ to $3\frac{1}{2}$ inches." Another gives its weight at "one ounce," and its length from "3 to $3\frac{1}{2}$ inches;" while the majority assign to the foetus a weight of from 3 to 4 ounces, and a length of from 4 to 6 inches. One speaks of the limbs as "having acquired their definite shape and proportions," with "nails as very thin plates," while another says "the first traces of the fingers

can be made out." These, and similar incongruities, cannot be otherwise than perplexing and misleading to students, for whose special benefit and guidance these several authors are presumed to labour and to write. If such is the unsettled state of the fountain, what must be the condition of the stream? Suppose, for example, an examiner has pinned his faith to the author of 70 grains and $2\frac{1}{2}$ inches, and the examinee to an author of 4 ounces and 5 inches, what then? Perhaps he will, to his dismay, find he has

"Pinned his gates with rushes."

If authors of such profundity and influence differ so widely on matters of fact, may not we exclaim

"The vast profundity obscure?"

The only author, within my reach, who exactly accords with Dr. Wilkinson in length and weight, viz., 6 inches and 2 ounces, wrote more than 60 years ago.

Now, gentlemen, you have heard the whole case, and thus you are placed in that happy position which will enable you to "prophecy after the event." I hope you will appreciate the privilege, and say whether I should have been justified in opening the abdomen when the first attack of collapse came on. If so, why, and upon what grounds would you have given your personal sanction to the operation? If the physical signs of rupture of the cyst had sustained my first impressions, the operation would not only have been justified, but demanded. These, however, were altogether absent, as well they might, seeing the case was one of intra-cystic hæmorrhage, and not of ruptured cyst. The total absence of the physical signs of rupture, and the actual presence of acute suffering along the course of the transverse colon, together with the highly distended condition of the rectum, with hardened and impacted feces, diverted my immediate attention from the actual cause, to what, subsequent events have shown, were only the reflex effects of the collapse. Perhaps, it may be said, that the operation was too long deferred—perhaps so; but before such an opinion is arrived at, the *post-mortem* report should be carefully studied, as well as the circumstances which surrounded the case from its commencement. These, I think, would imply, that if ever an operation could have been really beneficial, it should have been adopted immediately after the first collapse. But were the symptoms, at that time, sufficiently clear and defined to have justified abdominal section? This is a point upon which I should be glad to hear an expression of opinion. "Friendship gives a man a right and claim to the free opinion of his friends."

CASE OF BLOW ON RIGHT SIDE OF HEAD—AMNESIA—RECOVERY.

By ALFRED LONDON, M.D. (LOND.), ADELAIDE.

RECENTLY (March 18) a sad, fatal accident happened on the cricket field, through a collision between two players who were "fielding" a ball. The shock of collision must have been great, for both were stunned, and one, I believe, never recovered consciousness, but died after about a fortnight, with signs of inflammation of the brain and its membranes. The other speedily recovered consciousness, and was sick; when seen two hours after he was enjoying his tea. The only external marks of injury were slight bruises of the right knee, shoulder and jaw; he complained of headache, but it was at once obvious that his memory of recent events had completely vanished. He knew which day of the week it was, but could not recollect playing cricket that afternoon. His conversation was limited to very few phrases; when told that he had been injured, he always replied "That's a bad job;" he forgot what he had seen or been told a minute afterwards. Whenever his eyes rested upon me, he knew that I was a stranger, and invariably repeated the same expression, "I haven't the pleasure of knowing you," and was introduced to me at least a dozen times in as many minutes. To induce him to retire to bed I put on the hands of my watch to 11 o'clock, but he suspected this ruse and compared the time by his own watch, which indicated about 7.30 p.m. A minute after his watch was also put on to 11 o'clock, but he insisted on comparing it with a clock in another room, which had also been advanced. His power of writing and reading, unfortunately, was not tested. Bromide of potassium and chloral hydrate were prescribed, and he passed a good night. The next day he had no recollection of me or of my previous visit; he complained of severe headache, not, however, localised. On the second day after the accident he went to his work against advice, and his headache was much increased. He had now learnt the particulars of the accident, and kept relating them to his fellow clerks, quite unconscious of the repetition. It was also noticed that he left his hat or stick about and could not find them again. After a few days he was sent into the country; on his return, and as long as six weeks after the date of the accident, he had still headache, slight as a rule, but readily exaggerated by any mental or physical exercise, and his memory, though improved, was still imperfect.

I suppose that this would be classed as a case of concussion, but I am inclined to think that the amnesia, though slight and transient, is

sufficient to warrant us in diagnosing a lesion of Broca's convolution (the third left frontal) by contre-coup—either a contusion of the brain substance, or an effusion of blood beneath the pia mater.

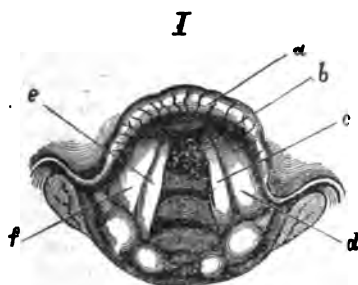
COCAINE IN SURGERY OF THE LARYNX. (*Illustrated.*)

By AUG. HOFF, M.D., ET CH.D., LEIPZIG, STATE'S EXAM., GERMANY; OF HYDE PARK, SYDNEY.

When Cocaine was first introduced into surgical practice it was chiefly used as a local anæsthetic in operations of the eye, and as such it quickly made its way all over the world. I read of its application for the first time in the transactions of the Medical Society of Vienna, and it at once struck me that it must also prove pre-eminently efficacious as a local anæsthetic in operations of the larynx. And, indeed, the very next mail brought an account verifying this anticipation. In point of fact it is almost self-evident that, if cocaine has proved a valuable adjunct in operations of the eye, its utility would be still more striking in all cases where the surgeon finds it imperative to operate upon the interior of the larynx. In operations of the eye the patient can, in most cases, if necessary, be put under the influence of chloroform, though, of course, the exhibition of this drug always implies trouble and some risk; but in intra-laryngeal operations, general anæsthesia is out of the question, as, in the first place, we want the co-operation of the patient, and as further consciousness during the operation enables the subject to expel the blood which would otherwise enter the lungs. Many means have therefore, from time to time, been tried to produce local anæsthesia in these cases, but at best no dependence could be placed on them, until at last the true remedy has been discovered in cocaine. The following case is a good illustration of the truth of this assertion:—

K. W., a young man of 25 years of age, had for a long period been subject to temporary attacks of huskiness, to which little attention was paid, until, in 1883, friends who only saw him at long intervals noticed that the hoarseness with which he was troubled had become more pronounced, and, in fact, permanent. In the month of August of that year he consulted a medical man, whose diagnosis

showed a slight swelling of the left vocal cord. No remedy, however, was attempted, and the patient was told that if it did not grow worse, he might leave the cure to the effects of time. Four months later, in December 1883, the patient arrived in Australia, and a gradual but certain change for the worse manifested itself, so that after a time his articulation became so much impaired that his interlocutors could frequently hardly understand him. Still more decided symptoms of serious disorder, however, set in about September 1884, when at times he would suddenly lose, in the course of conversing, the use of his voice altogether. In a word, he became aphonic, and it then usually took some time before he could again continue speaking. Attacks of this nature became by degrees more and more frequent, until at last, even in starting a conversation he also experienced no small difficulty in articulating, and was compelled to "clear his throat" several times before he was enabled to proceed. In this state he consulted several medical men, and amongst others, the late Dr. Fortescue, who told him that he would have to undergo an operation, and that for this purpose he would have to go to London, or still better, to Vienna. When I saw him on the 20th March of the present year I found a state of things as represented in Fig. I. All parts of the larynx

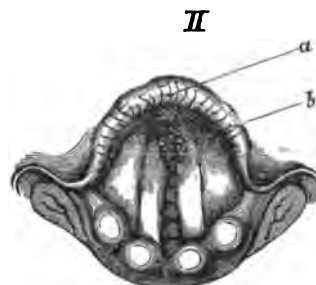


APPEARANCE OF LARYNX WHEN QUIETLY BREATHING.

a Epiglottis ; *b* Polypus ; *c* Chorda voc. sin. ; *d* Chorda voc. sin. spur. ; *e* Chorda voc. dextra ; *f* Chorda voc. dextra spur.

were of a red colour, and swollen. The true vocal cords were barely visible, as their view was obstructed by the swelling of the false vocal cords. Besides these general characteristics, I observed a slight swelling of a lighter colour on the interior surface of each of the vocal cords, but more pronounced on the left. The anterior angle of the glottis was occupied by a growth of glandular appearance, and of the size of a split pea. When quietly breathing, the vocal cords approaching each other as near as their swollen state would allow, almost covered the glandular growth or polypus,

but after a strong and sudden expiration, following a deep inspiration, the larynx represented a picture as shown in Fig. II. The polypus, as will be



APPEARANCE OF LARYNX AFTER AN ENFORCED EXPIRATION FOLLOWING A DEEP INSPIRATION.

a Epiglottis ; *b* Polypus.

Note.—This sketch has been drawn after the swelling of the false vocal cords had gone down.

seen, was projected through the glottis and held by the vocal cords—to use a homely simile—like a button in a button hole. Here we have an explanation why the voice of the patient suddenly gave way when speaking. The larynx was in a state of excessive irritability on which, as may be supposed, the repeated previous examinations and soundings had had anything but a calming effect, while on the other hand it increased the difficulty of complete and searching examination, as, at the slightest touch of the epiglottis or any other part the patient was seized with an irrepressible desire to vomit. In order to reduce the catarrh and the swelling, which proved to be of a secondary character, I applied locally astringents and iodoform, by which means the voice became better ; but the polypus, of course, required different treatment. Before removing it, however, it was necessary to allay or neutralise the excessive irritability of the larynx. The most time-honoured method adopted, is the constant introduction of the instruments used into the larynx, so as to habituate the parts to the contact with foreign substances ; but in the case under review I found this procedure impossible, as its application appeared to aggravate the catarrhal symptoms. Very much to my regret I found it impossible to procure any cocaine in Sydney, and therefore I next employed the local anæsthetic recommended by Professor Schrötter. I brushed the patient's larynx 8 o'clock in the evening twelve times with pure chloroform, followed by similar applications of a solution of morphia of the strength of 12 grains to 2 drams, the same number of times. The patient is given to understand that he must on no account swallow anything, and as a precaution, a gargle consisting

of a strong solution of tannic acid is used after each brushing. Schrötter asserts that the patient incurs no risk whatever; yet, when half-an-hour after the appointed time next morning—9 o'clock—my patient did not put in an appearance, I could not but experience some misgivings as to the result, and felt relieved when at last he arrived. On examination (9.30 next morning) of the larynx, I found it to some extent anæsthetic, but still not sufficiently so to justify me in proceeding with the operation. I, therefore, again applied the solution of morphia the prescribed (12) number of times, and after the lapse of an hour examined him once more. Again I was disappointed in finding the anæsthesia still unsatisfactory, and further brushings indispensable, only to experience a further disappointment an hour later, when the anæsthesia appeared to have absolutely diminished in degree, probably because the moisture discharged from the mucous membrane, which always set in after any interference with the larynx, had prevented the absorption of the morphia. Besides this, the symptoms exhibited by the patient—nervousness, incapacity of the stomach to retain any food, and trembling of the legs—decided me not to persevere with the treatment, and I consequently resolved to wait patiently for the arrival of a supply of cocaine which I had ordered and expected every day. Some weeks, however, elapsed before my anticipations in this respect were fulfilled, and before I could proceed to relieve the patient. Immediately after its receipt I applied a solution of the new drug, containing 20 per cent. of cocaine, and composed of 1 part cocaine, 2 parts rectified spirits of wine, and 3 parts distilled water, to the palate, pharynx, and larynx. The first sensation experienced by the patient, as expressed by himself, was that he had lost the power of swallowing, and when I introduced the instrument, I was told that he felt nothing. Thus, though the patient appeared somewhat nervous, the anæsthesia was perfect, and I had at last arrived at the desired result. I now introduced the polypus forceps of Schrötter, opened the glottis, and by a wrench removed the polypus. I may here interpolate that the implement referred to is, in my opinion, the only one that is applicable in cases of this kind. The circular knife or guillotine, can obviously only be employed when the polypus grows laterally in the larynx; but where, as in this case, it originates from the anterior angle, it is of no avail. Again, Schrötter's instrument, specially designed for similar cases which I show here, is apparently intended for polypi of very small size. To recur to the operation, I may add that immediately after removing the polypus, I thoroughly cauterised the wound with nitrate of silver. It will be interest-

ing to note that the duration of the anæsthesia was about 10 minutes, and that the incapacity to swallow was limited to the same time.

It will hardly be requisite to insist on the importance of the new drug as an anæsthetic calculated to facilitate surgical operations of the larynx, but it will also be evident that it is useful for diagnostical purposes.

It is a common experience of the surgeon that the mere introduction of a mirror is found unbearable by the patient, while by the simple application of a solution of cocaine the affected parts are rendered insensible to outward touch. It is certain that the discovery of cocaine will do more than all previous inventions to popularize laryngoscopy amongst the members of the profession, and deprive it of its terrors in the eyes of the public.

In its therapeutical aspects also, cocaine promises to become a most valuable aid in medical practice, as it may be used in alleviating the sufferings resulting from sore places in the larynx. Cases are on record where patients were in danger of losing their lives, not from the direct effects of the primary disease, but from sheer inanition, because the pain accompanying the act of swallowing absolutely prohibited them from taking the necessary nourishment. The application of cocaine at once does away with this terror. How valuable will it be found to be in removing foreign bodies from the larynx and pharynx, opening abscesses of the tonsils, and so on, or even in acute laryngitis and bronchitis. Of course to employ it at large, at present the scarcity of the drug and its high price are in the way.

If we take into consideration the surprisingly beneficial results obtained from the application of cocaine in diseases of the eye, the throat, the skin, the genital organs, and so on, we are not surprised to learn that its introduction into the practice of the medical profession has created such an immense stir amongst its members all over the civilized world. The only wonder is that a drug, discovered by Dr. Niemann fully 25 years ago, and the anæsthetic qualities of which, as regards the tongue, were well known, could so long escape general notice. It is true learned treatises were written about it, but, as many other good things, they remained buried in medical journals, till Dr. Koller, last September, demonstrated its practical value after systematical researches on its application on the eyes of dogs in the first instances, and subsequently on his own. Not the least recommendation of the new anæsthetic lies in the undoubted fact that its application is perfectly innocuous to the patient, and in no case on record have any unpleasant results been experienced.

ASSOCIATION INTELLIGENCE.

SOUTH AUSTRALIAN BRANCH.*

ANNUAL MEETING.

Held at the Adelaide Hospital, June 25th, 1885.

Dr. C. Gosse in the chair.

(Dr. Whittell, President of the Central Board of Health, was present as a visitor.)

REPORT OF THE COUNCIL.

THE Council has to report that during the past year several questions, affecting the profession generally, have received their earnest consideration. Amongst these was the causing fuller information, to be published quarterly by the medical board, of the qualifications, &c., of the practitioners registered under the Act. Also the appointment of a committee to consider, in an exhaustive manner, the whole question of unqualified practice, and the legal measures it would be advisable to recommend the Government to adopt. The labours of this committee have not yet been brought to a close. The council has also remonstrated with the civic authorities on their unjust and discourteous treatment of their health officer, Dr. Robertson.

The President, Dr. C. Gosse, also directed the attention of the Rev. Dr. Farr to the groundlessness of the charge which he had made against the members of the profession in South Australia, to the effect that they were often guilty of causing abortion. As result, the accusation was withdrawn by Dr. Farr in a subsequent issue of the "Register" newspaper.

The professional services of the Association have also been tendered to the Government in case of hostilities arising, and have been duly acknowledged.

In view of the starting of a medical school in connection with the University, the council has deemed it inadvisable for the Association to have a separate pathological collection. The specimens belonging to the branch have therefore been handed over to the able custody of the Professor of Anatomy and Pathologist to the Adelaide hospital, Dr. Watson. The thanks of the members are due to Dr. Poulton for his disinterested service in taking charge of the collection until Professor Watson was ready to receive it.

The increased size of the proceedings points satisfactorily to the work that has been done during the past year. The evenings devoted to discussion has been a new feature much appreciated by those members who were able to attend. The council regrets that it has had so few contributions from members living at a distance, and it would esteem it a favour if any suggestions could be made whereby the usefulness or the interest of the proceedings could be more extended to those who, from distance, are unable to be often present at the meetings. Letters, items of local medical matter, queries, &c., &c., from the members will always receive the careful consideration of the Council, and, as far as possible, find a place in the published proceedings of the Branch.

*We regret the delay in the publication of this report, which has arisen in consequence of the dilatoriness on the part of the authorities of the Branch in Adelaide in transmitting the *Mss.*, which arrived here too late for insertion in our last number.—ED. A.M.G.

The Branch consists of 72 members; eight new members having been elected since the last annual meeting.

The receipts for the year amount to £169 1s.; the expenditure to £153 5s. 7d.; leaving a balance at the bank of £35 5s. 11d.

The Hon. Treasurer, Mr. Corbin, then read and explained the items of the balance sheet, which was unanimously passed.

The retiring president, Dr. C. Gosse, then read the following

ANNUAL ADDRESS.

GENTLEMEN.—Although it is no part of the rules of this Society that the President should deliver an address during the period he holds office, yet I think it is a custom which prevails amongst all similar gatherings, and one which I hope to see regularly carried out in the future.

In the first place, gentlemen, I think we can congratulate ourselves upon having terminated a very successful year, as far as the work of the Society is concerned. We have had some exceedingly interesting and instructive papers; amongst others, that by Dr. Davies Thomas, on Hydatid of the Lung, stands out most prominently. As a result of careful study and useful tabulation of statistics, it will, I feel sure, be most acceptable to other observers. Dr. Stirling's successful case of supra-vaginal amputation of the uterus, by abdominal section; Dr. Gardner's paper on the surgery of the kidney; Dr. Verco's cases of necrosis following typhoid fever; Dr. Lendon's report of the cases of small-pox in the south-east, which led to an interesting discussion on what is called by the laity, native-pock; Dr. Mitchell's case of gall-stones with renal fistula; and Dr. Stirling's and my own case of pulsating exophthalmos.

And here I must thank the members for their consideration to me at all times during my occupancy of this chair. I can assure them that the year which has passed has been one of great pleasure, and I shall always feel deeply sensible of the distinction they conferred upon me a year ago when they elected me their president. I would also desire to tender my thanks to our excellent secretary, Mr. Cleland, without whom, I fear, it would be very difficult to manage our work.

In turning over in my mind the various subjects which presented themselves, I had some difficulty in selecting one which would be interesting, and one upon which I should feel some amount of confidence in addressing you. The present aspect of the profession in South Australia, or the growth of this Society, or some other local matter, each seemed to have a certain claim upon me, as I stand here this evening the oldest practitioner amongst you, of the second generation of medical men in the city—I mean, of course, as to the number of years in actual practice in Adelaide.

My selection has been a review of some of the recent advances in ophthalmology. And I feel I must crave your indulgence if I seem to have selected a subject which is, in reality, not of very great interest to the majority of the profession, but one which has a leaning towards the specialist. My excuse must be that I am very conscious of my inability of being able to address you at all, and, having chosen ophthalmology, I consider that I should be least likely to break down.

In March, 1884, Mr. John Tweedy introduced a new operation for the correction of secondary divergent strabismus. He says, in speaking of divergent squint,

that there is no form so disadvantageous to the patient or so troublesome to the surgeon. In operating for the cure of convergent strabismus, if after tenotomy of the internal rectus muscle we have the eye deviating outwards, it is certain there has been what is called "too free division"—not, of course, of the tendon, but of the muscular substance, or of the capsule of tenon. In past years this mishap seems to have occurred more frequently than it does in these days, though, as he says, the immunity of later times is due rather to good luck than good management. It is a good rule to lay down, in correcting convergent squint, that the total amount of convergence should never be corrected by operation, but that half to a line should be left in the worst eye for improvement by use of glasses, or simply time.

In Tweedy's operation the steps taken in its performance are exactly the reverse to those of the late Mr. Critchett's, which has generally been looked upon as the most usually adopted proceeding. The operation, as introduced by Tweedy, is performed as follows:—

1. The lids being kept open with a speculum, a fine silk thread is inserted into the conjunctiva and episcleral tissue in a line from the horizontal diameter of the cornea, and about 1-16th of an inch from the inner margin of the cornea. The ends of the thread are left long with the needle attached. (The preliminary insertion of this thread marks, and afterwards indicates, the horizontal meridian of the eyeball, and still later serves as a suture for the middle of the rectus muscle.

2. Next, a crescentic incision is made immediately to the nasal side of the thread, and through the conjunctiva only.

3. The conjunctiva is then gently detached from the under-lying capsule towards the caruncle, but only far enough to expose the insertion of the rectus muscle, not to strip the muscle.

4. A strabismus hook is then passed under the muscle.

5. While the hook is in position, fine silk threads are attached to the upper and lower borders of the muscle, and left long.

6. The hold of the threads having been tested by gentle traction, the muscle is divided on the hook. (The operator is now sure that he has secured the tendon.)

7. The muscle is then carefully raised by means of the threads, and any remaining attachments of the muscle to the globe completely divided.

8. The needle attached to the thread at the inner border of the cornea is passed through the middle of the divided muscle from within outwards, and in such a way as to penetrate the muscle and its sheath and over-lying conjunctiva. (By including the sheath and conjunctiva, not only is a firmer attachment obtained, but the relations of the muscle and its sheath are, as far as possible, preserved, at the same time that the shrunken caruncle is raised by bringing the conjunctiva forwards.)

9. The needles attached to the threads at the upper and lower borders of the muscle are now insinuated into the episcleral tissue, and made to emerge on the surface of the conjunctiva at about $\frac{1}{8}$ th of an inch from the upper and lower margins of the cornea respectively. This gives a broad and fan-like attachment to the muscle.

10. The external rectus is now freely divided sub-conjunctivally, and then, while an assistant rotates the eyeball inwards, the corresponding ends of the three sutures are closely and firmly tied and cut short.

Should shortening of the internal rectus muscle, or removal of redundant conjunctiva be deemed necessary, it may be done just before the ninth stage. Mr. Tweedy says only on one occasion did he find it necessary to abscise any muscular substance out of 15 times that he has performed this operation. Immediately after the operation there should be some convergence to ensure a permanent result, and no attempt should be made to exercise the muscle for a week afterwards. The dressing and after-treatment are simple. After washing the lids with a weak solution of boracic acid, or of chloride of sodium (1 per cent.), he applies to the closed lids a piece of lint on which a thin layer of boracic acid ointment (gr. 20 ad $\frac{1}{2}$ i) has been spread, and then ties up the eye with a light compress of cotton wool. The stitches are removed on the 4th or 5th day, if they do not fall of themselves.

This operation of re-adjustment of Tweedy's seems to me to be preferable to Critchett's operation in many ways. The plan of inserting the stitches before anything is attempted in the way of bringing forward the muscle is a much surer way of obtaining a strong hold of the muscle than the haphazard method of inserting the stitches the last thing. Then again, Critchett divides the external rectus first of all, and this favours rotation and other disadvantageous displacements of the globe, which are further increased when the internal rectus is cut through. In Critchett's operation the internal rectus is divided without any precaution being taken to establish its identity, so that when in the later stages of the operation it is sought to affix the sutures there is no certainty that what is secured is solely or wholly muscle, or even muscle at all. Then the unnecessary exposure of the internal rectus and the tendency to orbital cellulitis is increased in Critchett's operation.

A considerable amount of discussion has taken place during the last twelve months in reference to glaucoma, both chronic as well as acute. I shall not trouble you with any new methods of treatment of acute glaucoma, as none seem to be worthy of a place as antagonistic to iridectomy. There is no doubt that iridectomy is *par excellence* the operation for acute glaucoma. Mr. McHardy gives a paper in the "Ophthalmological Transactions" upon iridectomy in chronic glaucoma. He suggests a very large initial incision, which he makes by transfixion with a narrow, stiff, linear knife, in cases of primary chronic glaucoma, viz.: the external chord of the incision has a length equal to the diameter of the cornea (about 12 mm.), and externally the entire incision lies parallel with but one millimetre posterior to the margin of the cornea. At any rate, he says the incision should never be less than would suffice for an ordinary extraction of cataract; moreover, he says, "I see some hints that it may prove to be a pioneer of the practical treatment by removal of the lens in certain unpromising cases of chronic glaucoma." He has practised this incision in 30 cases, and in no instance has he been able to associate any unfavourable sequel with the exceptionally larger section. As a dressing, he has a double layer of lint over the closed eyelids, kept moist with cold boracic lotion. The nurse is provided with a pad of cotton wool, with which she is instructed to afford the eye temporary support, should the patient strain through vomiting, coughing, or ejecting excreta.

Mr. Lindsay Johnson has published a monograph on the treatment of chronic glaucoma by a scleral paracentesis. It amounts to this—an incision is made through the sclerotic, avoiding the external rectus muscle, into the vitreous humour. The rationale of the operation is,

that the cause of chronic glaucoma being the plugging of the lymph spaces in the vitreous humour. An incision into the latter body will give a free exit to the lymph. Possibly some of you present may recollect that I read a paper upon this subject in March last, and that my conclusions were not altogether favourable to the operation as performed by Johnson, and that I considered it in no way equal to iridectomy.

In July of last year a committee of the Ophthalmological Society was formed, instigated by Dr. McKeown, of Belfast, to investigate, as far as possible, the relative frequency of blindness from ophthalmia neonatorum. The report of this committee stated that about 30 per cent. of the inmates of the various Blind Institutions had suffered from ophthalmia neonatorum. The statistics that they collected agreed substantially with those of foreign investigators. They recommended the adoption, by the society, of the following resolutions:—

1. That the purulent ophthalmia of new-born infants being the cause of a vast amount of blindness, mainly because of the ignorance of the public regarding its dangerous character, and the consequent neglect to apply for timely medical aid, it is desirable to instruct those in charge of new-born children by a card, in substance as follows:—

Instructions Regarding New-born Infants—If the child's eye-lids become red and swollen, or begin to run with matter, within a few days after birth, it is to be taken without a day's delay to a doctor. The disease is very dangerous, and, if not at once treated, may destroy the sight of both eyes.

This to be distributed through the medium of the Poor Law and Birth Registration organisations of the United Kingdom to every case of labour under the Poor Law system.

2. That the advocacy and aid of the medical press be solicited in drawing general attention, and especially that of the authors of text-books on midwifery, of the lecturers on the same subject for students and midwives, and of the various institutions which train, and charitable institutions which employ midwives, to this important subject.

3. That a copy of the first resolution be forwarded to the respective Presidents of the Local Government Boards of the United Kingdom, and that a deputation be appointed to wait upon the said Presidents, and urge upon them the official adoption of the views therein expressed, and to take such other steps as they consider necessary.

These resolutions were unanimously adopted by the Society and forwarded to the Presidents as directed.

The reply which was received from the Registrar-General pointed out that the Registrars of Births could not be expected to perform any extra duty without adequate remuneration. Supposing a fee of 2d. were paid for each card read and presented, this would amount to a yearly expenditure of £7,300. Further, in many cases it was not the mother of the child who registered the birth; and, in conclusion, the Registrar-General inquired why, if instructions were to be given with regard to purulent ophthalmia, they should not also be given with regard to all the other maladies to which infants were liable? The whole scheme was impracticable in his opinion.

A special committee was then formed, which brought up the following abridged suggestion:—"That as, in the opinion of the Registrar-General, the reading over of a printed form by the Registrars of Births to the parents would entail a considerable expense, this may be

dispensed with, and that, in place of this reading, the following notice be printed on all official documents issued to parents in relation to the birth-registration and vaccination of children, namely: "If the eye-lids become red and swollen, or run with matter, within a few days after birth, the child is to be taken, without a day's delay, to a medical man. The disease is very dangerous, and, if not at once treated, may destroy the sight of both eyes."

This report was again unanimously adopted, and a deputation suggested to wait upon the President of the Local Government Board.

In the *British Medical Journal* of May 23rd, the President of the Ophthalmological Society announced that the Local Government Board would receive a deputation on the 15th May, in order to learn the views of the Society. It does not state the result of this meeting.

My own opinion is very strongly in favour of something of the sort being adopted in our own community, and I see no great obstacle to its being accomplished. We have at present a gentleman (Dr. Whittell) at the head of the Central Board of Health, who is always ready to meet us in matters of this sort, and I have serious intentions of bringing the matter prominently before the Society during the coming session. I have no means at present of ascertaining the exact percentage of cases of blindness from ophthalmia neonatorum in this colony; but such a statement could easily be obtained I have no doubt.

Dr. Mules, of Manchester, has contributed a paper on the Preventive Treatment of Sympathetic Ophthalmitis by Evisceration of the Globe, and the use of an artificial vitreous. In reviewing the history of the operation, he states that Müller and Graefe were working out the same operation at the same time as he was himself, without any previous interchange of ideas. He points to the result of this new operation as a further proof of the correctness of the views advocated by Snellen, Leber, and Max Kines, that travelling organisms are the cause of sympathetic ophthalmitis. Graefe's operation and his are identical; but in addition to the operation of evisceration, Mules prepares the eviscerated globe for the application of an artificial eye by the introduction of a hollow glass sphere, or artificial vitreous, which is permanently retained; by this means the shape of the globe is maintained, and very good movement obtained. The operation is performed as follows: The patient is anaesthetised; the hand-spray is used, and the appendages thoroughly cleansed and disinfected with a 1 in 1000 solution of corrosive sublimate; the front of the eye is transfixed and removed with a sharp knife at the corneo-scleral junction. He considers it better not to cut the conjunctiva. The contents of the globe are then emptied out in any way most convenient to the surgeon, taking special care to remove the ciliary body and choroid, leaving only a clean white sclera. The sublimate solution is allowed to run into the eye through a thin india-rubber tube, used syphon-wise, during the whole time the operation is in progress. The hand-spray is also employed as an additional precaution, and its use continued until all bleeding ceases. The sclerotic is then slit between the inferior and internal recti muscles, until the glass sphere selected can be introduced into the cavity. A cat-gut drain (removed next morning) is introduced into the lower angle of the wound, and the sclera sewn up from above downwards. A layer of finely powdered iodoform is spread over the whole conjunctiva, and a dressing of wood-wool in a double layer of Lyster's gauze is

applied. As a precautionary measure, the patient is kept in bed for four or five days; the eye dressed daily under the hand-spray. If the wound is kept aseptic the reaction is comparatively slight. If early suppuration ensues, the pain and distress is severe and prolonged. Too much stress, therefore, cannot be laid upon the necessity for antiseptic treatment, without which the operation should never be performed. Three sizes of artificial vitreous have been found, so far, to be sufficient. The paper is valuable physiologically, as showing that little or no inflammation need result from the wearing of such a glass sphere; and it is valuable ophthalmologically, as showing how extremely good a stump for the application of an artificial eye can be obtained by thorough evisceration. The late Mr. Hancock used to perform the operation of evisceration in cases of glaucoma, attended with hæmorrhage, but without, of course, any of the antiseptic precautions which, at the present time, renders many doubtful operations almost every-day occurrences. In the course of the discussion which followed the reading of this paper, Mr. Hartridge suggested celluloid as a substitute for the glass sphere, and I should imagine it was a very valuable alteration, as, in case of accident, the celluloid would only act as a soft buffer, whereas the broken glass might prove very dangerous.

Dr. W. A. Brailey has been energetic in his researches into the causation and pathology of sympathetic ophthalmitis. He maintains that it is due to sympathetic inflammation of the uveal tract. In his microscopical examinations he found cells either in small isolated clusters, or in a continuous layer on the lower part of the posterior surface of the cornea, and also round the blood-vessels of the optic nerve. The iris showed clusters of cells in its middle layers; or if the iritis were severe, the whole iris was densely packed with similar cells, and cells were also found making a stratum of adhesive inflammatory exudation on its posterior surface. Its blood-vessels had their walls thickened and their lumen occupied by a proliferation of the endothelial layer. If cyclitis accompanied the iritis, the inflammatory cells were mostly in the connective tissue layer of the ciliary body internal to the muscular fibres, where they were distributed either in clusters or in a dense stratum occupying its whole thickness. If the choroid were also implicated, the cells occupied similarly its middle layer, but no exudations on either of its surfaces could be found.

Since the above observations were made he has examined many more cases of sympathetic disease, both in their clinical and pathological aspects, and has been surprised to find in how large a proportion of them some structure other than the uveal tract is implicated, either conjointly with this, or to all appearance alone. For example—out of 53 undoubted cases of sympathetic inflammation of the uveal tract leading to excision which are comprised in 763 cases of enucleation in 5½ years at Moorfields, he noted 30 cases of pure uveitis, the iris being always implicated, the ciliary body often, and the choroid, in addition, sometimes. But dots were observed on the cornea in 14 of them, and a distinct kerato-iritis was found in 10. Also, he found 31 cases where, at the time of the excision of the first eye, there was in the other some ophthalmoscopic evidence of neuritis, such as redness and slight haziness of the disc. It may, with justice, be said that such appearances are difficult to be sure about, especially with regard to the variations in the colour of the disc. But the same reason would render them liable to be overlooked, and indeed they are far more common than has been represented, partly for this reason, and partly because the patient is often unable, on account

of the associated symptoms of sympathetic irritation, to bear the light of an ophthalmoscopic examination.

Closely allied to, and probably consequent upon, these morbid conditions, are atrophies of the disc, of which Brailey has observed one apparently due to sympathy, and haze of vitreous 4 cases, 2 being uncomplicated, 1 associated with choroiditis, and one with detachment of retina.

Brailey states that he has had to modify his previously expressed opinion as to the cause of the disease in the first or exciting eye. Formerly he supposed that the disease in the first eye was always a severe adhesive inflammation, and that this must be in activity at the time of the outbreak of sympathetic disease. For example—he found eyes that are shrunken and perfectly quiet after panophthalmitis may excite "genuine sympathetic iritis." Moreover, the condition in the exciting eye may vary extremely, and these various conditions may be the result of very different causes, from the most common perforating wounds, through spontaneous inflammations and blows with blunt instruments, to the rarest choroidal sarcoma. Again, the parts affected do not correspond in the two eyes. Iritis, or kerato-iritis, in the first eye, may give rise sympathetically either to a pure iritis, with occasional hypopion, a kerato-iritis, an iritis with keratitis punctata, or to an affection of the optic disc, or even vitreous body.

These facts, he says, are strongly opposed to the theory of direct transmission of the inflammation from one eye to the other by whatever route, whether by inflammatory cells in the blood, or by a continuous active neuritis, either of the ciliary or optic nerves. And there is no pathological evidence to show an actual travelling neuritis of any nerve as the cause of sympathetic ophthalmitis. The optic nerve in the first eye is usually swollen if it is true, but this occurs in any ordinary case of purulent iritis in a more pronounced way than in the majority of eyes exciting sympathetic disease.

He has examined the ciliary nerves in many cases, sometimes in the second, but more often in the first eye, but he has never seen any proof that an inflammation travelling along them is the cause of the transmission of the disease.

In cases where sympathetic disease occurs after excision of the exciting eye, we have in all marked symptoms of sympathetic irritation preceding the enucleation. Lawson has reported in the Moorfields Hospital Reports a case in which sympathetic inflammation came on after the lapse of nine years. Whether this case was, as the history given appears to indicate, considered simply as a relapse, or whether it was a primary outbreak of sympathetic disease, matters not as regards the theory of direct transmission. If the disease is communicated only by direct transmission, why should relapses occur as they do even in my limited experience, without any apparent corresponding difference in the condition of the first eye? Brailey asks what other theory can we accept conformably with the above observations? The symptoms of irritation produced in the second eye, whether such as pain, lachrymation, photophobia, obscurations, failure of accommodation, or perhaps even vascular congestion, can be satisfactorily explained by the transmission of the irritation from the first eye to a nerve centre, and then back through the corresponding nerve of the opposite side.

Out of 29 cases of sympathetic irritation taken at hazard, 16 were relieved, 7 were unaffected, and 6 were rendered worse by excision of the other eye. In the

first set of cases, the change must be merely a functional one, but in the others some permanent affection of the second eye must have resulted from the irritation of the other. Some similar cases to the above have been explained by the entanglement of the ciliary nerves in the cicatrix of excision, and others are clearly due to the irritation of the socket by an artificial eye. The first explanation is rather hypothetical, and the entanglement has very rarely been demonstrated, but the second is of tolerably frequent occurrence.

Brailley says that he is satisfied that a single eye is more prone than one of a pair to disease; for example, cataract (especially of the nuclear form), to iritis, and to corneal ulcers. And he ascribes this liability to an alteration in its nutrition depending on the previous occurrence of disease in the first eye, or even to the operation of enucleation itself. There is no doubt but that a defective eye is more liable to disease than a sound one. This is markedly shown in spontaneous suppuration of such eyes, and even in the occurrence of sarcoma in them.

It is also observed that eyes, the subjects of recent severe operations (for cataract, for example), are more liable than others to corneal infiltrations and iritis. It is also a fact that an injury or operation affecting an unsound eye is unduly likely to excite sympathetic disease especially if its fellow eye is also defective. For instance, needing operations for opaque capsule, after extraction of the lense, is very liable to start sympathetic disease.

If, then, sympathetic irritation is transmitted from one eye to the other through a functional nerve condition, and if the irritation, with or without an increased liability to morbid processes, persists after removal of the other eye, we can only ascribe it to an altered nutritive condition of the second eye. Why should not the same explanation be applied to the phenomena of sympathetic inflammation? The evidences of direct transmission are very slight. And it is clear that the more various the phenomena are shown to be, the more difficult it is to establish direct transmission. Also, how can direct transmission explain the occurrence of sympathetic disease, weeks, months, and even years after the removal of the first eye, and certainly very long after the subsidence of active inflammation in the first eye?

All these things will, however, be reasonably explained by the supposition of such an altered nutritive state of the second eye as would be induced by the morbid functional nerve influence derived from an inflammation, atrophy, or even absence of the first. This would render it liable, far beyond other eyes, to inflammations clearly dependent upon constitutional conditions—for example, syphilis and rheumatism, and to those which, for want of better knowledge, we term spontaneous. Such inflammations are severe; they are liable to recur; they attack parts most usually liable to inflammatory disturbances. Sympathetic ophthalmitis is marked by its severity and intractability, and its liability to relapse.

This able and instructive paper of Brailley's deals with the subject from so many points that I have been compelled to devote so much time to it; but we must ask ourselves the question, to what practical end does it all tend? Until recently—indeed the last 3 or 4 years—it was the invariable custom to excise the damaged eye at any stage after the sympathetic mischief had developed in the other. But, owing to the exertions of Critchett, Brailley, and others, we are taught to take certain precautions before recommending an eye, in which its fellow is involved, being removed. We may

lay down the following rules with regard to enucleation: An injured eye, which is blind, should be removed immediately after the injury, if possible. An eye which is injured, and remains inflamed without any useful sight, should be removed. No eye should be excised in which sympathetic ophthalmitis has once set in, as the removal of the exciting eye is not likely to benefit the patient nor stay the progress of the disease.

Dr. McKeown has written a paper upon the treatment of immature cataract. One of the fundamental rules regarding the extraction of cataract is, that we should wait until the cataract is mature. This rule is seldom departed from, and then with a considerable amount of misgiving. Patients are kept waiting for an indefinite period—it may be many years—while the process of ripening is going on; a period of gradual failing vision, perhaps of anxiety and failing health, or possible penury or destitution. Dr. McKeown says that among ophthalmic surgeons there will be unanimity on this point, that if we could only remove this barrier of immaturity, and devise some method of operating with success on all cataracts, no matter what may be their condition of maturity, we should confer a great boon upon the community, and add considerably to the *prestige* of ophthalmic science. The method which he has instituted for the maturing of the lens is termed intracapsular or intralenticular injection.

The reasoning which brought him to practice this method is very simple. We all know how tedious it is at times to remove cortical substance, and the necessity of waiting for the resecretion of the aqueous humour. Why, thought he, should this process not be shortened by injecting inside the capsule a little water of about the temperature of the body, to wash out the cortex, or at any rate facilitate its removal? A little pure water introduced into the eye is less likely to do harm to the structures than gold, silver, or steel instruments used as scoops. Besides, the water would exercise a certain force on parts which could not be safely reached by any instrument, and which too often contained fragments of the lens, the cause of destructive inflammation.

The methods of injecting fluids which he has used are:—

1. The introduction, within the capsule of the lens, of a needle attached to an ordinary hypodermic syringe. If there is any part of the lens substance easily disturbed, the injection usually ruptures the capsule a little at the point of puncture, and washes out masses quite easily, which could not be removed even by a scoop. This mode of injection is perfectly safe.

2. After removal of the nucleus, the introduction of water inside the capsule by gravitation from a bottle fitted with a tube. This requires a good deal of care, and involves the question of the force allowable, and the time during which the flow of water, and the syringing, can be safely continued.

It seems to me that the first method is a very feasible proceeding, and although I have never performed the operation up to the present, I shall take the first good opportunity of facilitating the maturity of a cataract, when I consider the surrounding circumstances justify such measures.

Dr. Wolfe, of Glasgow, has introduced a new operation for the cure of detachment of the retina. His operation is unlike that of von Graefe or Sir William Bowman, which consists of merely puncturing the retina with one or two needles, and allowing the fluid to escape beneath the conjunctiva. Wolfe's method is as follows: The speculum being inserted, and the eye fixed by an

assistant, a vertical slit is made with scissors into the conjunctiva and sub-conjunctival tissue, laying bare the sclerotic at a point corresponding to the site of the detachment, which is generally below the equator of its anterior aspect. The lips of the wound are separated by two small strabismus hooks, and the assistant steadily maintains the position of the eye-ball to prevent the exposed portion of the sclerotic from shifting. The sclerotome is introduced into the sac formed by the fluid. The incision through the sclerotic is made obliquely, in such a manner that the edges of the scleral wound should overlap each other when the instrument is withdrawn. Gentle pressure is made upon the eye-ball in the track of the receding lance. To make sure that the whole of the fluid has been evacuated, a little pressure with a fine silver spatula is made at the edge of the scleral wound. The lips of the external wound are brought together with a fine silk suture, and the two eyes strapped with court plaster. The patient is kept in bed in a dark room for three days. On the eighth day after the stitches have been removed the result of the operation may be tested. He relates several cases which have proved satisfactory, and has demonstrated his operation before the best ophthalmologists in Paris and London.

To what cases is this operation applicable is a practical question to ask? I think in cases of simple serous effusion, where the vitreous and choroid are healthy, there is a fair prospect of success. But in cases of detachment, complicated with disease of retina and choroid, or when the retina has been lacerated so that shreds of it are floating in the detachment, any operation would be useless. The prospect of a patient with progressive sub-retinal effusion is so extremely hopeless, if the case be left to take its course, whether from the patient declining operation or from other reasons, that I think Wolfe's operation should be tried.

And now I come to what I consider the most important discovery in ophthalmology since the introduction of atropine into our therapeutics, namely, hydrochlorate of cocaine, which was first brought under the notice of ophthalmic surgeons by Dr. Köller, of Vienna, on October 17th, 1884, in a lecture which he delivered before the Vienna Royal Imperial Society of Physicians. The history of cocaine, previous to Dr. Köller's experiments, was the following: Cocaine, the alkaloid first obtained by Niemann from the leaves of *erythroxylon coca* in 1859, was stated, in 1862, by Professor Schroff, to possess the property of anæsthetising the mucous membrane of the tongue. Dr. Hughes Bennett published his investigations on the uses of cocaine in 1872, and drew attention to the fact that the peripheral nerves of the skin and mucous membrane were paralysed by its application in small doses, while in larger quantity the deeper nerve centres were affected. In Bolivia and Peru, where the coca plant grows, the native Indians chew the leaves to appease hunger and thirst and support strength.

Dr. von Andep, in 1880, confirmed the facts pointed out by others, as to its controlling power over the nervous system, and hinted that it might be useful as a local anæsthetic, after which it was frequently employed in operations upon the throat. In October, 1884, Dr. Carl Köller, of Vienna, announced the results of his experiments, stating that when a few drops of a two per cent. to five per cent. solution of cocaine were put into the eye, in from 3 to 6 minutes complete corneal and superficial conjunctival anæsthesia took place, lasting from 15 to 20 minutes. Köller gives somewhat minutely the sequence of symptoms carried out upon

himself and a few colleagues, as follows: When a few drops of a 2 per cent. solution are introduced into the conjunctival sac, or better still, if they are allowed to run over the cornea, together with an increased secretion of tears, a slight burning sensation is felt, which disappears after an interval of from 30 to 60 seconds, to give way to an obscure feeling of dryness. To an observer the eye thus treated has a rigid expression, and it arises from a decided widening of the palpebral aperture. If, now, the head of a pin be brought into contact with the cornea, we note the absence not only of the pain usually associated, but we absolutely do not feel the contact, and all reflexes are absent. The same holds good for the conjunctiva, which loses its sensibility to heat and cold. Without the least inconvenience to the patient we can grasp hold of the conjunctiva with toothed forceps, or pit the cornea with pressure. From 15 to 20 minutes after the instillation the pupil begins to dilate; the dilatation reaches its maximum at the end of the first hour, decreases during the second hour, and disappears completely in a few hours more.

The anæsthetic effect of cocaine he found could be increased to a certain limit, that is, if cocaine is dropped into the eye after the partial cessation of the anæsthesia, a second complete anæsthesia results, which lasts longer than the first. In this way he has produced complete anæsthesia, lasting from 15 to 20 minutes from the last application, by a continuous repetition at intervals of 5 minutes. The anæsthesia is pre-eminently a local one—i.e., it is stronger on those places to which the solution has been directly applied and where it has been for some time in contact. By means of a continuous application, repeated every 5 minutes, with a 5 per cent. solution kept up for half an hour, he succeeded in producing such an effect upon the deeper parts of the bulb that its sensibility to strong pressure was almost obliterated.

During the last two months I have repeated the experiments made by Dr. Köller in a considerable number of cases, and I have much pleasure in stating that I can confirm his observations with regard to the valuable effects produced. The solution which I have been in the habit of using is a 4 per cent. solution of the hydrochlorate of cocaine, with a grain or two of salicylic acid to prevent the formation of fungus, which is very liable to occur. The hydrochlorate is easily soluble in water. Gelatine discs, of the strength of 1-200th of a grain, are now prepared by Savory and Moore at the suggestion of Mr. Nettleship, and are a very economical mode of using the drug, as two discs are sufficient to produce anæsthesia in about 3 minutes.

As regards the value of cocaine in operations upon the eye, I cannot speak in too high praise of it. By its use most of the unpleasant surroundings connected with operations are done away with. No ether is required, and in very few instances is it necessary to have an assistant. Most of the minor operations can be performed in the consulting room, and the patient goes home very soon afterwards. The following are the principal operations in which it has been tried:—

1. In removing foreign bodies from the cornea. Every surgeon knows how troublesome it often is to do so owing to the sensitiveness of the eye, and although atropine to a certain extent relieves this, still with cocaine the patient does not know when the cornea is being touched, and the foreign body can be easily removed.

2. The thermo-cautery has been applied to the cornea for sloughing ulcers without any pain.

3. In iridectomy the incision in the cornea is painless, but the iris, when dragged on and cut, causes pain in some patients, in others no pain is complained of.

4. It is in cataract operations that the greatest benefit seems to be derived from the drug. No pain is complained of, and patients state that they hardly know that anything is being done. Of course there is no fear of straining from vomiting as occurs often after the administration of ether; and also, there is very little tendency to bleeding, as the eye seems to be somewhat blanched after the application of cocaine.

5. In all needling operations on the cornea, like tattooing, and needling capsular cataract, no pain is complained of.

6. In squint operations it is very successful. The only soreness that is mentioned is in inserting the strabismus hook beneath the tendon of the muscle. But this I think will be remedied as we become better acquainted with the various methods of applying the drug.

7. The operation of enucleation has been twice performed in St. Petersburg without causing the least pain.

In one or two cases in which I have tried the drug, where there has been acute inflammation of the conjunctiva, it has not appeared to relieve pain, nor diminish the sensibility of the cornea or conjunctiva; but I have great hopes that as time goes on, we shall see much more brilliant results from the use of cocaine than anything we have yet witnessed.

I notice that the *Lancet* of the 9th May has a review of two books which have already been written on cocaine, one by Dr. Knapp, of New York, the other by Dr. Turnbull, of Philadelphia. The following characteristic quotation from Dr. Knapp's book is worthy of repetition: "It is characteristic of conservative England that medical men were waked up to the remarkable advantages of a new remedy six weeks later than their American brethren, whereas with an equal spirit of receptiveness and progressiveness they ought to have been two weeks before them."

I cannot close this paper without a word about Mr. Hutchinson's able and scholarly "Bowman Lecture" (a lecture instituted by the Ophthalmological Society in honour of their first President and benefactor, Sir William Bowman) on diseases of the eye in relation to gout. I have not time to discuss the paper, but suffice it to say it is written by Mr. Hutchinson, which means that it has been thoroughly thought out. It is not a lecture confined to the specialist, but one that all medical men would do well to study.

In conclusion, gentlemen, I cannot do better than quote a sentence from the speech of the President of the Victorian Medical Society, in his annual address, wherein occurs the following: "We cannot help reflecting whether it would not be possible for us in Australia to meet our professional brethren of the other colonies, in one metropolis or another, yearly, that we might imitate here on a smaller scale what the medical men of the older countries regularly accomplish, and unite a pleasant holiday making with professional intercourse of the widest, the most inspiring, and the most beneficial character. I trust before long the first annual meeting of the medical profession of all Australia will be held in one of our capitals, and prove the forerunner of our national aspiration, Australian Federation."

The following officers were elected for the ensuing year:—

Dr. Verco, Vice-President; Mr. Corbin, Hon. Treasurer; Mr. Cleland, Hon. Secretary; Drs. Astles, C. Gosse, and Poulton, Members of Council.

Exhibits:—Dr. Görger showed a patient whom he had seen with Mr. Hayward, at Kensington, on the 27th March last. Having satisfied themselves by examination with the speculum that it was a case of purely rectal cancer, the patient was advised to seek relief at the Adelaide Hospital, where he was admitted on the 27th of the same month. He expressed his indebtedness to Dr. Poulton, the house-surgeon, for the further notes of the case.

The patient, aged 44, a painter, 26 years in the colony, has suffered on and off for several years from piles, which, apparently ceasing to trouble him for the last four years, re-appeared, as he thought, seven months ago. Since then his pain and suffering have increased, accompanied by a gradual loss of weight and strength. There was no marked cachexia. Finding himself no longer able to work he consulted Mr. Hayward. On admission he complained principally of a painful straining during, and for some time after, defecation. A digital examination, without the employment of an anæsthetic, revealed a hard, irregular, but complete ring, about 1½ inches from the anus, and somewhat narrowing the gut. It was most pronounced anteriorly and extended quite out of reach of the index finger. Apparently not ulcerated, as examination causes no bleeding.

March 30th.—Suffering much local pain; bowels confined.

On April 1st, the patient being under ether, he (Dr. Görger) operated for the removal of the diseased part. Being unable to get beyond the disease by a circumferential incision, he carried it backwards as far as the point of the coccyx, through the ischio-rectal fossa. This gave more room and allowed of the removal of about 3 inches of the gut. As the cancerous infiltration extended still higher, he proceeded, with the help of his fingers and the handle of the scalpel, to liberate the gut to a still greater extent. The remaining carcinomatous zone was then brought within reach of the scissors by means of four silk traction sutures passed through the wall (not the lumen) of the bowel above the disease, and the integument without. These being secured, remained as ordinary permanent deep sutures. Before securing the last of the above sutures, he cut down and shelled out two isolated bean-sized nodules from the ischio-rectal fossa, leaving, however, numerous pin's-head to pea-sized ones behind. These proved afterwards, on examination, to be inflammatory products. Finally he passed a large drainage-tube deep in the hollow of the sacrum through the incision behind. The lower part of the rectum, now transformed into an anus, was plugged with salicylic wool, after having introduced a morphia suppository. On April 8th the plug was removed, pus flowing from the drainage tube; linseed poultices applied. April 8th, an area of red, tense induration was noticed in the right inguinal region. On the 13th this was incised, causing the evacuation of a quantity of pus. The sutures were removed. On the 15th the fecal accumulation in the rectum was controllable; the discharge decreasing and no pain. May 2nd, discharged. Had imperfect control over bowels, the orifice being large and patulous, but is improving in general condition. The temperature was mostly normal, and only once reached 102°6, when the abscess in the abdominal wall was forming.

The patient called every week, and a steady improvement was noticed until about the end of May, when he was attacked by diarrhoea, and lost flesh. He soon recovered again, and now weighs 30 lbs. more than when he was operated upon. The control over the bowels is now perfect; they are moved once daily, and he always knows when the time comes. He looks healthy and strong, and does not complain of any pain. He (Dr. Görger) said that the reason he had entered minutely into the case was that the members might judge of the respective merits of excision and colotomy. He thought the result spoke in favour of the former, as, besides giving relief, it held out the hopes of a definite cure, which colotomy never does. If the worst does come, colotomy can still be performed. The operation lasted over two hours, and he expressed his sense of the very able assistance he received from Dr. Stirling, and the careful after-treatment bestowed by Dr. Poulton, as tending greatly to the good result he was able to show that evening.

He referred to another similar case where the patient was a woman about 40 years of age. Two inches of the rectum was excised, the cancer having involved its whole extent. A rapid recovery took place, and she has complete control of the bowel. On an examination made that day, he discovered two rounded nodular growths in the gut, which could be easily removed when the patient's consent is obtained. Before the operation she suffered much pain and discomfort, which has been entirely relieved; and although a fatal termination may be looked for sooner or later, yet good has been done by procuring for her, at any rate, a period of apparent immunity and comfort.

He also exhibited a man, æt. 29, suffering from ectopion vesicæ urinariæ. It presented the appearance of a round red tumour of about 3 inches diameter, the uretus being visible at the base with urine dropping from them. The umbilicus was not very distinct, and from it the linea alba bifurcatis down to the os pubis, forming a triangle. The bones, united by ligaments, were distant about 2½ inches. The glans penis was large; the urethra and corpus spongiosum missing, the former being only represented by a groove on the dorsum penis, covered with mucous membrane and leading to the extraverted mucous membrane of the bladder. Testicles pretty large and in the scrotum. The especial feature of the case was that it showed the ejaculatory ducts and the caput gallinaginis.

Dr. Lendon exhibited an instance of pseudo-hypertrophic paralysis (the myo-sclerotic paralysis of Duchenne) in a boy aged 8, a patient of Dr. Way's at the Adelaide Children's Hospital. Dr. Lendon drew attention (1) to his posture when standing, the heels being raised off the ground, the enlarged calf muscles standing out in bold relief, there being also marked lordosis; (2) to his characteristic waddling gait; (3) to his clumsiness in lying down; and (4) to his evident difficulty in rising from the recumbent posture, the final portion of the act consisting in literally climbing up his own legs and trunk. Dr. Lendon mentioned that he had another case under observation in private: a boy, aged 4, whose maternal uncle had died from the same affection, but who was in a much earlier stage of the disease. With respect to this case, Dr. Thomas had recently sent him the results of his consultations with Drs. Russell, Reynolds, and Gowers—the latter, while not sanguine as to improvement, recommended tonics (and especially arsenic) together with the use of the Faradic current, massage, and methodical exercise of the affected muscles. Dr. Reynolds had, however, seen cases in which the patients had recovered sufficiently to allow of their indulging in riding, shooting, &c.

NEW SOUTH WALES BRANCH.

A general meeting of the New South Wales Branch of the British Medical Association was held on August 7, at the Royal Society's Rooms, Elizabeth Street, Sydney. Dr. O'Reilly occupied the chair.

A paper was read by Dr. Hankins on "A Case of Suppression of Urine, following an Operation for Stricture."

Dr. HOFF read a paper on "Cocaine in Surgery of the Larynx," which will be found on page 296.

Dr. KNAGGS remarked that it acted most rapidly on the conjunctiva and mucous membrane. It did not act fully for 10 minutes when applied to the skin. He believed, however, that as an anæsthetic it would create a greater revolution in the medical world than even chloroform.

Dr. MAHER described the effects of the drug when applied to his own eye, the cornea and conjunctiva becoming insensible to feeling. He thought, however, that if it caused coagulation of the blood it would interfere, in cases of cataract, with the removal of the anterior capsule and the soft matter.

THE CHAIRMAN stated that the solution would not keep for any length of time.

Dr. HANKINS said that this difficulty could be obviated by the addition of a single drop of chloroform.

Dr. CREED remarked that cocaine would be exceedingly valuable to check the dangerous convulsive spasms which resulted when any foreign body entered the larynx.

Dr. CREED, the hon. secretary, then read the following letter, which had been forwarded to the chairman by a layman:—

"Sydney, August 7. Dear Sir,—I must apologise for addressing you, but as I understand that you are the president of the Medical Association, I venture to bring under your notice a growing evil in the city, i.e., the vast amount of injury inflicted upon unsuspecting patients by these so-called 'nervous debility men,' who are a pest to society, with the hope that you may draw attention to the matter, with the view to giving it publicity at your meeting this evening, and doubtless any remarks so made will be taken notice of in the daily press. As one solitary instance of the incalculable injury these 'sharks,' for they are nothing else, have inflicted, I may mention that a young fellow of 25 was idiotic enough to place himself under one of these gentry for some nervous, trivial complaint, and the quack gave him 25 of what he termed a preventive bolus, to be used one each morning, for which he paid £2. Well, after using one of these things the result was violent cramps in the stomach, semi-coma, and profuse perspiration, the pulse being an abnormal height. These things were shown to me, and I found that they contained, amongst other rubbish, assafœtida. I persuaded the young fellow to hand me the box, which I immediately consigned to the fire. I have met scores of similar cases to the above, and I do think that, if legally-qualified men would come out of their shell a little and show these scoundrels up, they would be doing a good work. Many and many a young man is ruined in body and pocket by these advertising scoundrels, and I have no doubt, sir, that if you, who are so well-known here for your courteous attention, would only set this matter once going, it would be taken up and readily discussed, and so let people at least hear a warning voice on a matter that demands most serious and earnest attention."

DR. CREED said that this was a matter that had often engaged the attention of the profession, but as soon as they attempted to do anything their motives were misconstrued, and it was said that they were stopping heaven-born genius from practising. There was no Act in force in the colony to keep out such men, and under the circumstances he thought that the best course to adopt would be to appoint a committee of two or three to issue circulars to practitioners in the colony, police magistrates, and coroners, with a view of collecting evidence, so that a mass of particulars might be ready for a submission to a commission which might be appointed to investigate into the subject. Personally the doctors were not losers by these quacks, as might be supposed, but gainers through their presence; they suffered in their self-esteem, however, by, in the ordinary parlance of the public, having these men placed on the same footing as themselves. These people were practising all over the colony, while they were more numerous in Sydney than anywhere else, some of them being hardly able to read and write. He knew of one case in which a man was convicted and sentenced to be hanged solely upon the medical evidence of an unqualified man, whose qualification to give medical testimony consisted in his having occasionally assisted a surgeon in a country hospital to make a post-mortem examination. The body of a man was found with a number of wounds on him, one being the cause of death. On the deductions drawn from the examination by this would-be surgeon a case of murder was made out, and the prisoner was sentenced to be hanged, though personally he (Dr. Creed) was convinced that the man had committed suicide. But for the evidence he was the means of bringing before the Executive Council the man would have been hanged; and he was now in gaol. There was another case in which a man went to one of these unqualified practitioners and offered him £50 to be made a Doctor of Medicine. An agreement was arrived at, the man paid £9 on account, attended at the quack's place and saw him treat his patients. At the end of a week he found that he could not pay the £50, and offered £30, when the quack told him he could only teach him medicine in proportion to the money paid. This man remained in this queer school of medicine for a few weeks, then put a plate on a door in one of the streets of Sydney as "Dr. So-and-so, surgeon," and commenced practice. A woman was injured; the case came before the Police Court, and this man was examined, and his evidence accepted as that of an expert. On another occasion the same person was called in late at night to see a woman found dead. The acting-coroner directed him to make a post-mortem examination, but he prudently refrained from doing so, and the jury was kept waiting for some time until a qualified man was called in and performed the duty. These were only two cases, but there were hundreds more occurring in the colony.

DR. KNAGGS said that he did not think they could do anything in the matter, but simply to endeavour to call attention to the state of affairs. This was the only one of the Australian colonies without a proper Medical Act, and as a result the quacks came here from all parts.

DR. CREED remarked further that the public were apparently desirous that the dispensers of drugs should be properly trained, but were not so anxious that those who wrote the prescriptions which these persons would dispense, should possess the requisite training and knowledge. This was a peculiar anomaly.

The matter then dropped, and Dr. Hankins was elected to fill the vacancy in the council, caused by the death of Dr. Fortescue. The meeting then terminated.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, SEPTEMBER 15, 1885.

EDITORIALS.

PROVISION FOR THE CARE OF THE WOUNDED IN AUSTRALASIA IN THE CASE OF WAR OCCURRING.

THE authorities in Melbourne contrast very favourably with those in Sydney in relation to this most important matter. In the former, a Commission has been appointed to enquire into the accommodation at present obtainable, and to recommend such additional provision as may appear necessary; to report on the present medical staff, which is really efficient; and to make recommendations as to the best way of increasing it should emergency arise; and also the best method by which the ambulance corps, as at present organised, may be quickly increased. Accommodation for 305 wounded is now available in the Alfred Hospital, Melbourne, and the hospital at Geelong; and the Commission recommends that State school buildings near the scene of action shall be utilised if required, a complete fit out of the necessary furniture being kept in store ready for immediate transmission to the places where they may be required. The fire brigades, it is recommended, should be trained in ambulance duties, and be required to hold themselves in readiness for such service, should they be wanted, whilst the medical students, it is suggested, should be utilised as dressers in the hospitals. This is as it should be, and is a great contrast to the state of affairs in Sydney, where, though great interest is being taken in military affairs generally, no medical staff worthy of the name can be said to exist, many medical practitioners of professional standing declining to join it under existing circumstances, though, when refusing, expressing their intention of doing all that lies in their power in an independent position, to aid the wounded, should hostilities break out. Were proper enquiries made the reason of this state of things would not be far to seek. By the exercise of a proper decision it might soon be put an end to, and a proper scheme

formulated, when, without doubt, all our leading operative surgeons would willingly, though at some inconvenience, place their services at the disposal of the Government, for the aid of their fellow colonists, in such a way that an efficient staff might be organised, and the special training, which adds so greatly to the efficiency of a military hospital, undergone before the immediate necessity arises. In New South Wales we have Dr. Williams, who, as principal medical officer of the Soudan Contingent, with his two juniors, Drs. Glanville and Proudfoot, have seen some service in the field, and should, therefore, be able to do good service in the organisation of a medical staff. There are also surgeons attached to various volunteer corps, but there appears to be no attempt at anything like combined action, nor does there seem to have been any attempt to ascertain how the necessary hospital accommodation might be provided when occasion arises, or to embody and train an ambulance corps or staff of dressers. This is a state of things which requires prompt attention and vigorous and decided action.

BABY FARMING.

A CASE which has aroused much public attention has lately brought to light an establishment carried on by a midwife named Mary Anne Baker, at Lane Cove, near Sydney, for the care of children, principally illegitimate, whose parents find their charge inconvenient. One having died, it came to the ears of the neighbours, who reported the case to the police, and an inquest was held, at which evidence was given showing a very undesirable state of affairs to have existed in our midst. Mrs. Baker, it appears, was in the habit of leaving her establishment to the charge of a deputy, named Charlotte Wells, it being but a branch of her principal establishment, a private lying-in house, in Elizabeth Street, Sydney, where she herself resided. So complete was the state of isolation in which the Lane Cove branch was kept by the direction of Mrs. Baker, that it appears in the evidence that Charlotte Wells was with the children in her charge two days and two nights without fire, she having had no matches, and having been told by her employer on no account to go near her neighbours on any excuse whatever. The cause of the death of the child appears to have been natural, and to such effect was the verdict of the jury, who, however, added a rider stating that "the jury unanimously recommend that the said baby farm be suppressed, and attention was also drawn to a former recommendation to the same effect, given at the inquest on Daniel Russell, on the 10th of October, 1879, which seems to have been disregarded." From informa-

tion obtained during this case it became known that another child, the offspring of Charlotte Wells, had died without having been attended to by a medical man, on June 15, 1885. This child was born in April of this year, and so was two months old at the time of its death. It was, however, buried as still-born, under the authority of the following certificate from Mrs. Baker: "I certify that I delivered Mrs. Wells, of Crown Street, of a *mile* child, *primeturely*. M. A. Baker, June 15, 1885." As a document authorising the burial of a dead body, this certificate is of very considerable interest, though we fear by no means unique in New South Wales, for although it does not even certify that the child was dead, much less gives any cause for the death, it was received and acted on by the cemetery authorities with the utmost simplicity and faith. We think that the radical change in the law with regard to the registration of deaths in New South Wales, which is so urgently required, and which we have so persistently advocated, notably in our editorial on page 31 in vol. 2, and again in our recent article on cremation, cannot, with such cases as these constantly occurring, be much longer delayed.

CONFERENCE OF DELEGATES FROM VICTORIAN HOSPITALS.

A MEETING of gentlemen representing a number of the country hospitals of Victoria met in Melbourne on August 20th, to discuss the position of these institutions, especially with regard to Government aid. It was shown that there was great inequality in the grants made to the various institutions, and that, whilst some received at the rate of £50 to £60 per bed, others got £15 only, and that there was no fixed rule as to the amount institutions should receive, but that it depended in a great measure upon the political influence which they could bring to bear upon the Government of the day. The Conference very properly made a strong protest against this state of things, and a resolution was passed which suggested a certain fixed rate, based upon the number of beds in the institution subsidised. The meeting approved of the principle of admitting as paying patients those who have not fitting accommodation in their own homes, but who are sufficiently well off to pay for the benefits thus received; we regret to say that no mention was made of the remuneration of the medical officer by such patients for his services. It should never be lost sight of that a surgeon who is the paid medical officer of a hospital receives his stipend for the treatment of the patients who are too poor to pay, and that it is unjust to expect him to treat well-to-do people for nothing, because the committee think fit to admit them to

the hospital as paying patients. A protest was also made against a recent notification from the Government to the governing bodies of the various country hospitals, that they would have to provide accommodation for lunatics, which, we think, was just and well-timed, for nothing could be more unsuitable or dangerous, both to the lunatic and other patients, than that such a proposal should be carried into effect. It would be impossible for the attendants at a country hospital, fully engaged as they would be in the fulfilment of their ordinary duties, to give proper attention to such cases, and some terrible incident would quickly happen which would show the necessity for an immediate change. We are of opinion that in country districts a special room should be attached to the various police stations for the accommodation of lunatics, not necessarily to every lock-up, but in such numbers as might be required, so that one would be within say twenty miles of any given spot, and it should also be placed where medical aid would be available. It was decided that this Conference should be held annually, Mr. Kavanagh, of Mooroopna, being appointed chairman, and Mr. West, of the same place, secretary. A deputation was introduced by Mr. Langdon, M.L.A., to the Chief Secretary, to bring under his notice the resolutions passed by the Conference.

COMPENSATION FOR PROPERTY DESTROYED TO PREVENT THE SPREAD OF SMALL-POX IN VICTORIA.

A CASE, *Smith v. the Essendon Local Board of Health*, which came before the Supreme Court of Victoria on Sept. 3, 1885, on appeal from the County Court, in which the plaintiff was nonsuited in his attempt to obtain payment of the value of certain bedding and linen destroyed by order of the health officer, Dr. Turner, acting in his official capacity, he not having received any instructions from the Local Board, is one which we think should arouse very strong attention on the part of the public. Nothing is more essential to the prevention of the spread of a contagious disease such as small-pox, than that any vehicle for the conveyance of infection should be rendered absolutely harmless, and this can, in regard to the bedding which has been in contact with the patient, be only effectually done by its destruction. We fear that the pettifogging spirit which animates the Essendon Local Board of Health will act very prejudicially by raising a spirit of doubt in the minds of people in whose house a case occurs, as to their chances of compensation for property destroyed, and so things may be kept which will be the source of infection to others. It should be remembered that it is much more to

the interest of the public that infected goods should be destroyed than to that of the inhabitants of the house in which the case has occurred, for they have already been fully exposed to the contagion, and have either taken the disease, or have had their immunity proved to them by their escape, and are consequently in no further danger by the non-destruction of the infected things. All important as this matter is in small-pox, it will be of infinitely greater consequence should cholera break out in Australia, for the destruction of the bedding stained by the discharges of the patient is the only means of disinfection practicable, for it has been shown again and again that any attempt to wash the infected bed linen almost invariably results in the death of the laundress. We earnestly call on the people of Victoria to make loud and vigorous protest against this dangerous and expensive parsimony. The petty money-grubbing spirit in this matter is no new thing, nor is it in Victoria confined to the Essendon Board, for in our December number we called attention to the dispute which had occurred as to whether compensation should be paid by the Central or Local Boards of Health.

THE NEW PRINCIPAL MEDICAL OFFICER OF NEW SOUTH WALES.

By the retirement of Dr. Mackellar, consequent on his summons to a seat in the Legislative Council, this office became vacant, and the Government have appointed Dr. H. N. McLaurin to the post. We congratulate the colony upon this appointment, for we know no one more admirably fitted for this important office. Dr. McLaurin, after some years service in the Royal Navy, settled in practice first in Parramatta and afterwards in Sydney, where he occupies the position of one of our foremost practitioners. He has filled all the leading honorary positions at the various hospitals, he is Examiner in Medicine at the Sydney University, and Principal Medical Officer of the Mutual Life Association of Australia. He is eminently cultured, possesses the high esteem of the general public, and is beloved by his professional brethren, to whom his kindness and courtesy are unbounded. The duties of the post are somewhat modified by the appointment of Dr. Ashburton Thompson as Inspecting Medical Officer, to relieve Dr. McLaurin from some of the less important duties of his onerous position. Dr. Thompson has acted in a similar capacity under Dr. Mackellar, though not officially gazetted, and the colony owes him a debt of gratitude for the zeal, skill, and decision displayed in the discharge of his duties during the late outbreak of small-pox.

THE HON. C. K. MACKELLAR, M.L.C.

By the summons of this gentleman to a seat in the Legislative Council, the colony of New South Wales has undoubtedly sustained a loss in his retirement from the office of Principal Medical Officer, which, but for the acceptance of the position by Dr. McLaurin, would hardly have been compensated by the gain to the country of his services in legislation in the Upper Chamber, where, in the discussion of the Public Health Bill, in a great measure the offspring of his brain, he will be especially valuable. The zeal, decision, and talent which he has displayed during his tenure of office has been remarkable, and he has made his mark in the sanitary proceedings of the whole continent. His success in stamping out the late outbreaks of small-pox is unprecedented. His improvements in the structure and management of the Sydney Quarantine Station have made it the best and most complete in the world, and have removed every hardship except that of compulsory isolation from the persons quarantined. If we get the much to be desired federal action in quarantine, it will be owing to his initiation and advocacy of the step. In relation to the just increase of remuneration for professional services rendered to the Government by medical practitioners, especially in the country, the profession as a body owe him a debt of gratitude. We heartily congratulate him on his elevation, and feel that through him deserved consideration has been shown to the claims of the medical profession for representation in the Legislature of the colony.

THE MONTH.

NEW SOUTH WALES.

OUR readers will be pleased to learn that the claims of the profession to be represented in the Legislative Council have at last been recognised by the Government, as Dr. C. K. Mackellar, late medical adviser to the Government, and Dr. J. M. Creed, editor of the *A.M.G.*, have been summoned by the Governor, with the advice of the Executive Council, to the Legislative Council of N. S. Wales, under the great seal of the colony.

In the Legislative Council, on September 8, the Hon. Dr. Mackellar moved, and the Hon. Dr. Creed seconded, the adoption of the address for presentation in reply to the speech delivered by his Excellency the Governor, on the occasion of the opening of Parliament.

THE Public Health Bill, a measure containing 323 clauses, was read a first time in the Legislative Council, on September 9, and the second reading is set down for Wednesday, September 16.

DR. H. N. MACLAURIN, of Sydney, has been appointed Medical Adviser to the Government, Chairman of the Immigration Board, Health and Immigration Officer for Port Jackson, also President of the Board of Health, vice Dr. C. K. Mackellar, resigned.

DRS. S. T. KNAGGS and Geo. Marshall, both of Sydney, have been appointed Members of the N. S. Wales Board of Health, in the room of Drs. Fortescue and West, deceased.

AT a meeting of the Senate of the Sydney University, held on August 17, the following resolution was carried on the motion of Professor Dr. Stuart—"That a demonstrator in physiology be appointed, at a salary of £350 per annum, with tenure of office from year to year, the gentleman appointed to take office on March 1, 1886."

AT the Sanitation Conference, held on August 12, it was resolved that a committee be appointed from the Institute of Architects, the Engineering Association, the medical section of the Royal Society, and others, to inquire into and report upon the best system, or combination of systems, of sewerage, suitable to Sydney and suburbs, and the inland towns of the colony.

FIVE cases of dengue fever were discovered by the Assistant Health Officer on board the A.S.N. Co.'s steamer "Gunga," which arrived in Sydney Harbour from Fiji and Noumea, on August 17.

IN consequence of the prevalence of dengue fever in Fiji, it has been decided to quarantine vessels coming to Port Jackson from any Fijian port for a period of eight days. Quarantine is to date either from the removal of the last case of fever from the vessel, or should no sickness have occurred on board during the voyage, from the date of departure from Fiji.

THE Moruya Hospital Committee have decided to erect a building to cost £700.

THE following practitioners have been appointed Magistrates of the colony, viz.: Dr. R. G. Alcorn, of West Maitland; Dr. W. C. Ashe, of Newcastle; Dr. L. Fitzpatrick, of Queanbeyan; Dr. P. T. Thane, of Yass; and Dr. W. McMurray, of Walgett.

DR. L. W. BICKLE, late of Gawler, S.A., has commenced practice at Silverton, the centre of an extensive silver-mining district, 800 miles S.W. of Sydney.

DR. ALEX. MACKINTOSH, formerly Resident Surgeon of the Ipswich Hospital, Qu., has commenced practice at Mitchell, the centre of the Sunny Corner silver mines, 125 miles W. of Sydney.

DR. E. ATHERTON may be expected to return to Sydney about November 30, as he has taken his passage by the P. & O. str. "Carthage," which will sail from London on October 22.

DR. T. M. KENDALL, of 50 Macleay-street, Darlinghurst, Sydney, has removed to 36 College-street, Hyde Park.

DR. A. H. MEEKE, a new arrival, has settled at Candelo, in a farming district, 258 miles S. of Sydney.

DR. W. MURRAY has commenced practice at Armidale, the centre of a large agricultural and pastoral district, 813 miles N. of Sydney.

DR. ROSS, M.L.A., of Molong, met with an accident on August 24, when visiting a patient. His horse boited and he was thrown out of his buggy, one of the wheels of which passed over him, breaking two of his ribs.

DR. J. S. WILSON, formerly of Melbourne, and late of Walgett, has commenced practice at Kiama, the shipping port of a dairy-farming district, 92 miles S. of Sydney.

ABSCESS IN THE BRAIN.—On the 1st of August a child was admitted into St. Vincent's Hospital, Sydney, suffering from symptoms of cerebral abscess. Dr. W. Odillo Maher, who at a previous operation had removed part of the frontal bone, passed a knife nearly two inches into the brain, and striking the abscess, let out about two ounces of pus. The child made a good recovery, and is now walking about, apparently perfectly sane and well.

NEW ZEALAND.

DR. GRABHAM, Inspector of Hospitals in New Zealand, has sent us his report for 1884, which shows that the total number of Hospitals in the colony is 38; but one of these, the Greytown Hospital, he thinks might be closed, as the Masterton Hospital could very well serve for the Greytown district also. The number of in-patients admitted to all the hospitals during the year was 6,268, viz: 4,756 males, and 1,512 females. Of these, 992 were treated at the Dunedin Hospital, 791 at Auckland, 582 at Christchurch, 552 at Wellington, 372 at Napier, 332 at Invercargill, 324 at Hokitika, 190 at Thames, 183 at New Plymouth, 167 at Timaru, 156 at Lawrence, &c. The number of deaths in all the hospitals was 559, and of these 103 occurred at Auckland, 89 at Dunedin, 58 at Christchurch, and 50 at Wellington. The principal causes of deaths were—105 from phthisis, 47 from cancer, 47 owing to fractures, 41 from heart disease, 36 from pneumonia, 21 from typhoid, 20 from paralysis, and 19 from Bright's disease. The total receipts of all the Hospitals during the year were £60,222 12s. 11d., including £44,994 14s. 6d. contributed by the Government. The expenditure amounted to £67,825 18s. 4d., of which £1,957 9s. 5d. was expended for alcoholic liquors.

THE usual monthly meeting of the Canterbury Medical Society was held at the Christchurch Hospital on September 10, when motions were passed that the list of members be corrected, and that the bye-laws be revised. An interesting paper was read by the President, Dr. S. A. Patrick, which we hope to publish in an early issue.

THE compound prepared and sold for the destruction of vermin, known as "Rough on Rats," containing arsenic, has been proclaimed a "poison" within the meaning of "The Sale of Poisons Act, 1871."

DR. M. A. CHILTON, Resident Medical Officer at the Wellington Hospital, has resigned.

DR. G. S. CLAYTON, late of Fairfax-road, London, has commenced practice at Rangiora, 20 miles N.W. of Christchurch.

DR. A. CHALLINOR PURCHAS has commenced practice at Auckland, in conjunction with his father, Dr. A. Guyon Purchas.

QUEENSLAND.

JOSEPH NEEDHAM SCROPE SHRAPNEL, M.R.C.S., Eng., 1864; L.S.A., Lond., 1863, who for the last eight years practised at Brisbane, died in July last.

DR. T. D. ATKINS, late of Condobolin and Candelo (N.S.W.), has settled at Ipswich.

DR. F. BOWE, from Leeds (Eng.), has commenced practice at Maryborough, and Dr. W. Dunlop (late of Glasgow), at Dalby.

DR. L. W. DAVIES, late of Sydney, has settled at Mount Esk, a post town, 60 miles S.W. of Brisbane.

DR. J. H. LITTLE, of Brisbane, was thrown from his buggy on September 9, and sustained a serious shaking.

SOUTH AUSTRALIA.

AT a late meeting of the Legislative Council of South Australia, the Hon. H. Scott, M.L.C., laid upon the table of the house copies of letters written to the *Sydney Morning Herald* by the editor of this journal and Mr. Willows, on the "Inoculation of Rabbits with Tuberculosis," and moved that "they be printed." A discussion on this matter is to take place shortly.

A MICROSCOPICAL Society has been formed at Adelaide, which it is proposed to affiliate with the Royal Society.

DR. STIRLING, of Adelaide, is suffering from a serious attack of typhoid fever, contracted while on a visit to Lake Alexandrina, in the south-east.

TASMANIA.

DR. G. F. HUSTON, of New Norfolk, has resigned his commission as a Coroner of Tasmania and its dependencies.

HENRY ALBERT LOVETT, M.R.C.S., Eng., 1876, formerly Assistant Medical Officer of the Worcester Lunatic Asylum (Eng.), and late Surgeon in the Royal African Mail S.S. Co's service, died at Swansea on August 30.

VICTORIA.

THE Central Board of Health has issued a printed circular directing attention to the great mortality resulting in Victoria from typhoid fever, and to the urgent need of lessening the ignorance and consequent neglect of sanitary laws which prevail in regard to this disease. The circular contains information as to the cause of the fever, directions for its prevention, and instructions for its management in the absence of medical aid.

A SUIT was commenced in the Equity Court, Melbourne, on August 17, before Justice Molesworth, by the Attorney-General, at the instance of the Lunacy Commissioners, to set aside the transfer of the Northcote Inebriate Retreat by the trustees of that Institution to Dr. Chas. McCarthy, the present superintendent. The Institution was commenced in 1871 as a charitable one, by a public meeting in the Town Hall, and was supported by public subscriptions and a Parliamentary grant. The asylum was opened about two years afterwards, and about the middle of 1877, the Institution being in debt, the trustees transferred it to Dr. McCarthy on consideration of being relieved from all liabilities. Mr. Justice Molesworth gave his decision on September 8, which was to the effect that Dr. McCarthy only held the institute in trust, and that the property was really vested in the Crown.

DR. WILLIAM GILLESPIE, residing at Corryong, sued Robert Gregory for £1000 damages for libel, before Justice Williams and a jury of six, on August 20. The defendant was a travelling agent for the Colonial Mutual Life Insurance Company, and he fell out with Dr. Gillespie who was travelling with him. He wrote letters stating that the doctor was a fraud, and that he had no legal qualifications to practice. The plaintiff, who was qualified, though he was at that time not registered in Victoria, obtained a verdict for £750.

DR. BRIERLEY, late Assistant Medical Superintendent at the Beechworth Asylum, states that in two months that Institution had received 15 fresh cases of mania, which were due to the operations of the Salvation Army in the district.

THE Chief Secretary has severely censured Dr. McLean, Health Officer, Williamstown, for giving the

steamer "Oceanien" a clean bill of health two days before she arrived in Melbourne.

THE City Council of Melbourne have elected Dr. Jamieson Health Officer for the city, by the casting vote of the Mayor, over Dr. Springthorpe.

THERE have been a number of cases of diphtheria at Avoca, several of which terminated fatally.

OUR London correspondent informs us that Dr. E. M. James, of Melbourne, who, it will be remembered, accompanied the Marquis of Normanby home, is about to return to the colony by the P. & O. steamer "Carthage," which is advertised to leave London on the 22nd October. On the voyage out Dr. James will act as Medical Adviser to the new Governor of New South Wales, Lord Carrington and suite, who are coming out by the same steamer.

AT a meeting of the Committee of the United Friendly Societies of the Creswick district, held on August 27, Dr. M. W. Chambers, of Hamilton, was appointed Medical Officer out of eight applicants.

DIPHTHERIA has been very prevalent at Carlton and East Melbourne.

SICKNESS is very prevalent in the Dunolly district.

DR. WILLIAM BONE, M.D., St. Andrews, 1862, M.R.C.S. et L.S.A., Lond., 1859, J.P., died after a very short illness, at his residence, Barker-street, Castlemaine, on September 1. Dr. Bone arrived in Victoria from Tasmania in 1865, and practised for some time afterwards at Bacchus Marsh. About 16 years ago, he settled in Castlemaine, where he has had a very successful practice. During his residence in that town he was identified with many public movements, and took an especially prominent position in athletic and scientific matters. At the election for three members of the Local Board of Advice in July, he was returned at the head of the poll; and, on the 13th August, on the occasion of the annual municipal elections, he was second on the list with 574 votes. It was his intention to have contested the constituency at the next general election. As a prominent mason, Dr. Bone was highly respected, and was widely known for his extended charity. He held the appointments of Health Officer and Public Vaccinator for the Castlemaine district, and was a retired surgeon-major in the Victorian militia. The deceased gentleman was 49 years of age, and leaves a widow and two sons.

JAMES BURN MALCOLM, L.F.P.S., Glas., 1852, who for more than 30 years practised in the Castlemaine district, died at his residence, Hargreave Street, Castlemaine, after a short but painful illness, on August 20.

WALTER CHARLES PIERCE, L.A.H., Dub., 1829; L.R.C.S., Irel., 1840, who had resided at Dunolly since 1854, died at his residence on August 21, after a long and painful illness, at the advanced age of 85.

DR. J. E. WILLMOTT, of Collins-street East, Melbourne, met with an accident on August 24. He had driven down Spring-street in his gig, and when turning into Flinders-street the horse went on to the tramway line, and, owing to the slippery state of the wooden blocks with which the line is being paved, slipped and fell. Dr. Willmott was thrown violently to the ground, and received some nasty cuts on the head, which, however, were not of an alarming character.

DR. CUTTS, of West Melbourne, has been re-elected unopposed to the seat on the council of the Melbourne University.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Meeke, Arthur Henry, M.B. et Ch.M., Dub., 1885.
 McClinton, Charles, L.R.C.S., Irel., 1873; L.R.C.P., Edin., 1880; F.R.C.S., Edin., 1880.
 Munro, William John, M.B. et C.M., Edin., 1884; M.R.C.S., Eng., 1885.
 Brinton, Roland Danvers, M.B., Cantab., 1884; M.R.C.S., Eng., 1882.
 Wilson, Peter Birnie, M.D., Cal. Med. Coll., U.S.A., 1884.
 Sabatowski, Joseph, M.D., Paris, 1879.
 Semple, Andrew, M.B. et Mast. Surg., Glasg., 1883.
 Johnston, William Henry, L. Med. et Surg., Dub., 1874.
 Ellis, Henry Augustus, M.B., 1884; Ch.B., 1885; Univ. Dub.
 Parkinson, Charles Joseph, M.B., Lond., 1884; M.R.C.S., Eng., 1882; L.S.A., Lond., 1882.
 Scott, Hubert Payne, L.S.A., Lond., 1872.
 Featherstonhaugh, William, M.B., Dub., 1866; L.R.C.S., Irel., 1867.
 Cooper, Ernest Frederic, M.R.C.S., Eng., 1875; L.R.C.P., Lond., 1875.
 Gannon, Diego, L.R.C.S., Irel., 1883; L.K.Q.C.P., Irel., 1884.

NEW ZEALAND.

Hall, Thomas Gibson Henry, L.R.C.S.L., L. et L. Mid., K.Q.C.P., Irel., 1863.
 Dalsell, Isaac William, L.R.C.P. et R.O.S., Edin., 1879.
 Clayton, Geoffrey Sherborne, M.R.C.S.E., 1884; L.S.A., Lond., 1883.
 Purohas, Arthur Challinor, M.B. et Ch.M., Edin., 1884; M.R.O.S., Eng., 1884.

QUEENSLAND.

Davies, Louis Walter, M.R.C.S., Eng., 1877; L.R.C.P., Edin., 1878.
 Wood, William Edward Ramsden, M.B., 1877; M.D., 1880, Edin.; F.R.C.S., Ed., 1878; M.R.C.P., Ed., 1880.
 Button, Horace Gooch, M.R.O.S., Eng., et L.S.A., Lond., 1870.

SOUTH AUSTRALIA.

Korff, Berthold, M.D.

VICTORIA.

Graham, George Robert Moore, L. et L. Mid., K.Q.C.P., Irel., 1863.
 Beckett, Thomas George, L.R.C.P. et R.C.S., Edin., 1880; L.S.A., Lond., 1880.
 Elmer, Frederick William, L., 1882, F., 1885, R.C.S., Irel.; L. et L. Mid., K.Q.C.P., Irel., 1882.
 Hammond, Samuel, M.R.O.S., Eng., 1858; L.S.A., Lond., 1858; L.R.C.P., Edin., 1860.
 Low, William Houston, L.R.C.S., Edin., 1883.
 Malcolmson, John Finlay, L.A.H., Dub., 1832; L.F.P.S., Glas., 1835.
Name restored to Register:—
 Veltch, James William Henry, L.S.A., Lond., 1849.
Additional Qualification:
 Joake, Alexander Sydney, Ch.B., Melb., 1885.

MEDICAL APPOINTMENTS.

Cassella, Thomas, M.D. et Ch.M., Glasg., to be a Surgeon in the R.V. Force, S.A.
 Dalziel, James, L.R.C.P., Edin., L.F.P.S., Glasg., to be an additional Public Vaccinator for the Drury district, N.Z.
 Fishbourne, John William Yorke, M.B. et Ch.M., Dub., to be Health Officer for shire of Kelior, Vic.
 Fitzgerald, Edward Maxwell, L.R.C.P. et R.C.S., Edin., to be Govt. Medical Officer at Gayndah, Qu.
 Gardner, William, M.D. et Ch.M., Glasg., to be a member of the S. A. Medical Board.
 Hare, Francis Washington Everard, M.R.O.S., Eng., M.B., Durh., appointed Assistant Resident Surgeon at the Brisbane Hospital.

Johnston, Arthur Alma, M.K.Q.C.P., Irel., L.R.C.S., Edin., to be Govt. Medical Officer for the district of Parkes, N.S.W.
 Korff, Berthold, M.D., to be Public Vaccinator for Adelaide, S.A.
 Lepper, Robert John, L.R.C.P. & R.C.S., Edin., to be Public Vaccinator for the Murray district, W.A.
 Lillie, Heinrich, M.D., to be Govt. Medical Officer and Public Vaccinator for the district of Moree, N.S.W.
 MacDonald, William Craig Christie, M.B. & Ch.M., Glasg., to be Resident Surgeon of the Hospital for Pacific Islanders, Ingham, Qu.
 Main, Harry Findlay, M.B. & Ch.E., Melb., to be Health Officer for Malmesbury, Vic.
 Murray, William, M.B., Dubl., M.R.C.S.E., to be an additional Vaccinator for the district of Armidale, N.S.W.
 Norman, Walter, L.R.C.P., Ed., M.R.C.S.E., to be Public Vaccinator for Adelaide S.A.
 Partridge, William Strowd, L.S.A., Lond., to be Govt. Medical Officer and Vaccinator for the district of Port Stephens, N.S.W.
 Symons, Mark Johnston, M.D. & Ch.M., Edin., appointed hon. Ophthalmic Surgeon to the Adelaide Hospital, S.A.
 Thorp, Charles Gabourel, M.B. & Ch.M., Edin., to be Govt. Medical Officer and Vaccinator for the district of Blayney, N.S.W.

OBITUARY.

HENRY BUTLER, F.R.C.S., ENG.

DR. HENRY BUTLER, M.H.A., late Speaker of the House of Assembly, died at his residence, "Stowell," Battery Point, Hobart, on Saturday evening, August 21. He represented the Brighton constituency continuously for 31 years, and held office once as Minister for Lands. He was appointed Chairman of Committees in 1876, and in the following year he was appointed to the Speakership, which he held to the beginning of the present session, when he resigned in consequence of enfeebled health. He also held the positions of Chairman of the Board of Education and of President of the Commissioners of the New Norfolk and Cascades Hospitals for the Insane for many years. He was a Member of the Tasmanian Court of Medical Examiners and Honorary Consulting Surgeon of the Hobart General Hospital. He became a Member of the Royal College of Surgeons, England, in 1843, and a Fellow in 1849. Throughout the colony he was universally respected, and by the poor in particular his name will ever be held in affectionate remembrance. His goodness and charity to them were unbounded. He had been ill for a long time from disease of the heart and liver, and death was fully expected. The funeral took place on August 25. The procession was a very large and representative one, and amongst those who attended the funeral were a number of clergymen, including the Anglican and Roman Catholic Bishops, members of both Houses of Parliament, and a large number of private citizens. Both Houses of Parliament adjourned out of respect to the memory of the late Speaker.

CORRESPONDENCE.

THE INDISCRIMINATE SALE OF POISONS.

(To the Editor of the A.M.G.)

SIR,—Observing in last night's *Herald* that there had been a case of chlorodyne poisoning at Albury, I have to relate another case which occurred here on the 2nd inst. An old woman (set. 65) of intemperate habits, employed as a general servant, was brought to the hospital at 6 p.m. in a cart. On questioning her before she was removed inside, I elicited that a short time previous she had taken the contents of a bottle of chlorodyne and thrown the bottle away. As I had some doubts on the matter, I hastened to the store, and on making enquiry found that about an hour before she had purchased a bottle of chlorodyne in her employer's name, by whom, they then discovered, it had not been ordered. On returning to the patient I found a very strong smell of chlorodyne, and that it was beginning to take effect. Emetics were given, but as they were slow in acting, I used the stomach pump, and washed out the stomach thoroughly. Strong coffee was afterwards administered, and she was kept awake for some hours; but as I had to leave on a long journey at 9 o'clock, I did not see her until my return on the following evening, when she was considerably better, although still inclined to sleep. On the 6th instant, being sufficiently recovered, she was discharged from the hospital. Had this case not been in the way of early remedies, it would probably have been fatal, and it is only one of the many which are constantly occurring. Although there is a *Poisons Act*, still the Government are careless in *this*, as in all other matters relating to sanitation and the public health.

THOMAS LANE, L.R.C.S.I., L.K.Q.C.P.,
 L.M. ET S. Sc. CERT.

Warralda, N.S.W., 8th June, 1885.

PRINTED TESTIMONIALS.

(To the Editor of the A.M.G.)

DEAR SIR,—Before leaving Scotland, I considered it prudent to obtain testimonials from the leading gentlemen in the profession in Edinburgh, particularly in view of my coming to settle in the colonies, and specially for the satisfaction of medical brethren, such as yourself, to whom I am unknown.

For the sake of convenience I got these printed, and would have forwarded you a copy; but, after what appeared in your paper the other month, I hesitate unless assured it did not, in your estimation, amount to what is characterized as "touting." It is done, however (I mean the printing of testimonials), by professors and lecturers of the highest standing in Great Britain without considering it derogatory to their dignity when applying for professorships or other appointments such, as hospital, insurance, &c.

I am, yours respectfully,

W. S. F.

[We did not condemn the printing of testimonials nor their distribution to gentlemen in whose hands power to appoint a medical officer is vested—this, we think, is legitimate—but the distribution of printed testimonials by the practitioner himself amongst *private patients* and their friends. This we know to have been done, and we, in our article in the February number, emphatically expressed our disapproval of it, as we do now.—*Ed. A.M.G.*]

REPORTED MORTALITY FOR THE MONTH OF JULY, 1885.

Cities and Districts.	† Population.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from							
				Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Child-bearing.
N. S. WALES.											
Sydney	103,379	216	64	...	1	6	1	7	12	18	1
Suburbs	120,832	269	112	...	2	8	1	13	7	20	8
NEW ZEALAND.											
Auckland	28,501	34	14	...	...	1	...	...	2	3	...
Christchurch	16,432	15	7	...	...	...	...	...	...	3	...
Dunedin	24,965	25	7	...	...	...	...	...	1	3	1
Wellington	23,029	38	14	...	...	2	...	...	...	2	...
QUEENSLAND.											
Brisbane	26,557	44	15	} ...	...	5	...	8	3	8	...
Suburbs	9,612	47	7								
SOUTH AUSTRALIA.											
Adelaide	319,668	336	128	...	...	14	...	14	6	29	5
Adelaide	43,969	73	14	...	...	...	...	6	...	11	...
TASMANIA.											
Hobart	29,795	32	7	1	...	...	...	3	1	7	...
Launceston	18,515	20	8	...	...	1	...	...	...	...	2
Hospitals, Asylums, Gaols, &c. .	1,249	41	...	...	...	...	...	...	...	...	...
Country Districts	83,102	101	...	3	...	8	2	...	1	...	...
VICTORIA.											
Melbourne	65,791	...	...	...	...	...	...	...	...	...	...
Suburbs	238,618	...	...	...	...	...	...	...	...	...	...

† The population of N. S. Wales, Victoria, Adelaide, and Queensland, is that of the census of 1881; New Zealand, South Australia, and Tasmania show the estimated population at the present date.

METEOROLOGICAL OBSERVATIONS FOR JULY, 1885.

STATIONS.	THERMOMETER.				Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.		Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E. ....	...	64.2	51.2	35.	30.008	Inches	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.	119	64.	55.	40.	...	5.670	18	70	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	138	78.5	60.	37.	30.208	0.05	2	71	S.W.
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E. ....	...	...	...	...	...	...	...	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.	100	56.	42.6	31.	...	2.340	13	86	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E. ....	...	58.4	44.2	29.5	30.140	.93	17	88	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E. ....	...	57.9	43.5	24.9	30.212	3.06	8	84	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	...	...	...	...	...	...	...	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E.	64.7	52.9	42.6	30.232	7.45	20	75	W.
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	115	57.5	46.8	33.	...	4.320	21	86	...

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